MCH2010

Enhancing the health of Kansas women and children through partnerships with families and communities.

Kansas Maternal and Child Health 5-Year Needs Assessment

Bureau for Children, Youth, and Families
Kansas Department of Health and Environment

2005

K A N S A S

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

May 9, 2005

Dear Fellow Kansans:

It is my very great pleasure to provide a foreword to the five-year Maternal and Child Health Needs Assessment for the State of Kansas.

We all know that children are resilient and adaptable. But we also know that they are vulnerable to changing health, environmental, and societal conditions. A better understanding of the trends in the health of children and the circumstances that influence those trends can enhance our understanding of how Kansans should proceed in addressing vulnerabilities and enhancing resiliencies.

At the same time, when there is increased emphasis on performance accountability, downsizing, scarce resources at the local, state, and federal levels, it is imperative that our public policy and program decision-making be as well-informed as possible. When there are competing, powerful interest groups vying for scarce resources, it imperative that we bring together all the key stakeholders with an interest in the health of children, to review the data showing trends and predictive of future direction.

Informed decision-making and involvement of key stakeholders in decision-making are the foundation upon which this document is based. Key stakeholders were involved in meetings during which they examined the data and shared their own understanding of key issues. ***Nine state priorities for the years 2006-2010 were selected.***

I hope that you will join with me in supporting the selected priorities through your own efforts and those of our Department.

Sincerely,

Howard Rodenberg, MD, MPH
Director of Health

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Kansas Maternal and Child Health 5-Year Needs Assessment

Executive Summary

As a recipient of federal Title V - Maternal and Child Health Services Block Grant funds, Kansas is required to complete a statewide maternal and child health needs assessment every five years. Kansas' five year needs assessment, referred to as MCH2010 because it covers the period of federal fiscal years 2006 to 2010, has resulted in an identification of priority needs for the maternal and child health population.

The Bureau for Children, Youth and Families (BCYF) within the Kansas Department of Health and Environment (KDHE) coordinates the needs assessment and administers Title V funds. The mission of the Bureau for Children, Youth, and Families, which was a theme of the MCH2010 needs assessment, is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities."

During the summer and fall of 2004, 77 Expert Panelists participated in MCH2010 and identified priority needs for each of the three maternal and child health (MCH) population groups: Pregnant Women and Infants, Children and Adolescents, and Children with Special Health Care Needs. The priority needs identified by the Expert Panelists are as follows:

Pregnant Women and Infants

- Increase early and comprehensive health care before, during, and after pregnancy.
- Reduce premature births and low birthweight.
- Increase breastfeeding.

Children and Adolescents

- Improve behavioral/mental health.
- Reduce overweight.
- Reduce injury and death.

Children with Special Health Care Needs

- Increase care within a medical home.
- Improve transitional service systems for CSHCN.
- Decrease financial impact on CSHCN and their families.

Three additional focus issues were also chosen: (1) reduce teen pregnancy and sexually transmitted diseases, (2) improve oral health, and (3) improve asthma diagnosis and treatment.

The Panel of Experts drafted specific strategies for addressing each priority need and focus issue. Expert Panelists also assessed the capacity of the state MCH system and recommended first steps for KDHE staff to provide leadership in systems development.

The draft document was posted on the KDHE website for a 90 day public comment period which ended May 6, 2005. The final needs assessment report is submitted with the MCH Title V Block Grant Application on July 15, 2005. The beginning of the federal fiscal year on October 1, 2005 marks the official implementation of actions and strategies to address priority needs.

MCH2010 represents only the first steps in a cycle for continuous improvement of maternal and child health. Between 2005 and 2010, actions and strategies will be implemented, results will be monitored and evaluated, and adjustments will be made as necessary to continue to enhance the health of Kansas women, infants, and children.

Acknowledgements

Many individuals were integral to the MCH2010 process.

The **MCH2010 Expert Panelists** are listed below. These individuals represent a broad range of expertise in maternal and child health issues. They were the central decision-makers for the assessment process.

Susan Arnold, Families Together

Mary Baskett, Kansas Head Start Association

Mary Ann Bechtold, Special Health Services-Topeka

Kristin Blevins, Consumer Representative

Dena Bracciano, Douglas County Infant Toddler

Ginger Breedlove, Kansas University School of Nursing

Melissa Brooks, Coordinated School Health Program

Jane Byrnes-Bennett, Midwest Dairy Council

Ted Carter, BCYF, KDHE

Judy Clouse, BCYF, KDHE

Lynne Crabtree, American Lung Association

Cindy D'Ercole, Kansas Action for Children

Juanita Dewey, Thomas County Health Department

Patricia Dunavan, KDHE

Kathryn Ellerbeck, Developemental Disabilities Center

John Evans, Stormont-Vail Regional Medical Center

Eileen Filbert, Jefferson County Health Department

Allison Koonce, Coordinated School

Jimmie Gleason, Kansas Medical Insurance Co.

Lizbeth Gogolski, Stormont-Vail Regional Medical Center

Greta Hamm, KS Dept. of Social and Rehabilitation Services

Norm Hess, March of Dimes

Janelle Hill, Consumer Representative

Pat Hirsch, Mitchell County Health Department

Abby Horak, Public Management Center

Rosie Howlett, Wyandotte County Health Department

Kathy Johnson, T.A.R.C.

Jacqueline Jones, FirstGuard

Jean Jorgensen, University of Kansas - Beach Center

Nancy Jorn, Lawrence-Douglas County Health Department

Pam Keller, KS Dept. of Social and Rehabilitation Services

Jamey Kendall, KDHE

Jane Kennedy, Special Health Services-Topeka

Linda Kenney, KDHE

Jamie Kim, BCYF, KDHE

Jamie Klenklen, BCYF, KDHE

Guadalupe Klos, Crawford County Health Department

Health Program

Joseph Kotsch, KDHE

Darrel Lang, Kansas State Department of Education

Martin Maldonado-Duran MD, Family Service & Guidance

Monica Mayer, KS Dept. of Social and Rehabilitation Services

Marcia McComas, Special Health Services-Wichita

Julie McCoy, Special Health Services-Wichita

Dawn McGlasson, KDHE

Ileen Meyer, KDHE

Vicki Miller, Developmental Disabilities Center

Carol Moyer, BCYF, KDHE

Carolyn Nelson, Infant Toddler Services

William Pankey, First Guard Health Plan

Gianfranco Pezzino, Kansas Health Institute

Amanda Pierpont, Consumer Representative

Jennifer Prince, Consumer Representative

Wm. Randy Reed, Dept of Neonatology Wesley Med. Ctr.

Matt Reese, Developmental Disabilities Center

Pat Rion, Crawford County Health Department

Candice Rukes, Consumer Representative

Debra Rukes, YWCA Teen Pregnancy Prevention Program

Elaine Rupp, Hays Area Children's Center

Kathy Ryan, Thomas County Health Department

Kristi Schmitt, Finney County Health Department

Georgetta Schoenfeld, Logan County Health Department

Judith Seltzer, Reno County Health Department

Mary Ann Shorman, Kansas School Nurse Organization

David Sierra, Consumer Representative

Maria Sierra, Consumer Representative

Jan Stegelman, Kansas Safe Kids

Jane Stueve, KDHE

Theresa Tetuan, KDHE

Cyndi Treaster, KDHE

Christine Tuck, KDHE

Dale Walters, Catholic Community Services

Mary Washburn, KDHE

Polly Witt, Garden City Public Schools

Debbie Wolfe, Sterling Medical Center

Each MCH2010 Expert Panelist was assigned to one of three workgroups: Pregnant Women and Infants, Children and Adolescents, and Children with Special Health Care Needs. Assisting each work group was a team of three individuals: a facilitator, a data expert, and a recorder. The individuals who provided this assistance to the workgroups are listed below.

Workgroup	Pregnant Women and Infants	Children and Adolescents	Children with Special Health Care Needs
Facilitator	Jean DeDonder, Emporia State University	Ted Carter, BCYF, KDHE	Donita Whitney-Bammerlin, Kansas State University
Data Expert(s)	Carol Moyer, BCYF, KDHE	Carol Moyer, BCYF, KDHE Connie Satzler, EnVisage	Jamie Kim, BCYF, KDHE
Recorder	Judy Clouse, BCYF, KDHE	Jamie Klenklen, BCYF, KDHE	Julie McCoy, Special Health Services - Wichita

Connie Satzler of EnVisage Consulting in Manhattan, Kansas served as **Project Manager** for MCH 2010 with the assistance of her staff, Rebekah Brown, Wendy Popp, and David Ray.

Marjory Ruderman from Johns Hopkins University Women's and Children's Health Policy Center served as **Facilitator for MCH Capacity Assessment** at the third meeting of Expert Panelists.

The following individuals planned the assessment process and provided **Project Oversight:** Linda Kenney, Director, Bureau for Children, Youth and Families; Jamey Kendall, Director, Children with Special Health Care Needs Section; Ileen Meyer, Director, Children & Families Section.

Introduction

Each year, the Kansas Department of Health and Environment (KDHE) receives approximately $4.9 million through the Maternal and Child Health Services Title V Block Grant from the Maternal and Child Health Bureau of the Health Resources and Services Administration.

Maternal and Child Health Population Groups:

- *Pregnant Women and Infants*
- *Children and Adolescents*
- *Children with Special Health Care Needs*

As a recipient of Title V funds, Kansas is required to complete a statewide needs assessment every five years to identify the need for

- preventive and primary care services for pregnant women and infants,
- preventive and primary care services for children, and
- services for children with special health care needs (CSHCN)

Kansas' five-year needs assessment, referred to as MCH2010 because it covers the period of federal fiscal years 2006 to 2010, has resulted in an identification of the priority needs of the maternal and child health (MCH) population over the next five years. Specifically, three priorities were identified for each of the three MCH population groups (Pregnant Women and Infants, Children and Adolescents, and Children with Special Health Care Needs).

"Provide leadership to enhance the health of Kansas women and children through partnerships with families and communities."

- Mission of Kansas maternal and child health program

The Bureau for Children, Youth and Families (BCYF) within KDHE coordinated the needs assessment, administers Title V funds, and will provide leadership for addressing priority needs over the next five years. The mission of the Bureau for Children Youth, and Families, which became a theme of the needs assessment, is to "provide leadership to enhance the health of Kansas women and children through partnerships with families and communities."

Background

Title V

The Title V MCH Block Grant program serves over 27 million women, children, youth and families in all 50 states, the District of Columbia and eight U.S. territories. Authorized under Title V of the Social Security Act, the MCH Block Grant is the only federal program devoted to improving the health of all women, children, youth and families.

To learn more about the Title V program, refer to the Title V Information System (TVIS) website at https://performance.hrsa.gov/mchb/mchreports. This website includes financial and program information, indicator data, grant applications, and the most recently submitted five-year needs assessments for Kansas and all other Title V grant recipients.

Kansas MCH Needs Assessments

The first comprehensive maternal and child health five-year needs assessment was completed in 1995 and covered the period of 1996 to 2000. The second comprehensive needs assessment was completed in 2000 for 2001 through 2005. These needs assessments drew heavily from quantitative data such as demographic data, health status data, and other health-related data. In 2003, a mid-course review of the 2001-2005 needs assessment was completed, which drew heavily from qualitative studies, including interviews with local health departments and focus groups with consumers.

Needs Assessment Process

Overview

The MCH2010 process built on lessons learned in the previous two needs assessments. Quantitative and qualitative data were still used, but the process was organized around stakeholder involvement. Three one-day meetings with stakeholders were scheduled.

Meeting 1:

- *What is the plan?*
- *What else do we need to know?*

Meeting 2

- *Based on available data, what are the priorities?*
- *What are strategies for addressing the priorities?*

Meeting 3

- *What is the capacity of the MCH system to meet the priority needs?*

Date	What Was Accomplished
June 25, 2004	Overview of needs assessment process Identification of additional data needed
August 16, 2004	Review of data indicators Selection of priority needs Preliminary identification of strategies to address priorities
October 29, 2004	Identification of strengths, weaknesses, opportunities, and threats Evaluation of Kansas MCH capacity

Organizational Structure

MCH2010 Planning Team

An MCH2010 Planning Team was identified, which consisted of the following members: BCYF Director, Children & Families Section Director (representing both the pregnant women & infants and children & adolescents population groups), Children with Special Health Care Needs Section Director, both BCYF MCH epidemiologists, a contracted project manager, and the three facilitators (one internal to BCYF and two contracted facilitators).

For Meeting #3, Marjory Ruderman from Johns Hopkins University Women's and Children's Health Policy Center, provided leadership in MCH Capacity Assessment. Ms. Ruderman was a developer of CAST-5 (Capacity Assessment for State Title V), which is a set of tools for MCH Title V programs to use in assessing capacity.

Stakeholders: MCH2010 Panel of Experts

"I found the networking to be professionally and personally interesting. I see that Kansans may not network enough – between professionals and professions, geographic areas, between government entities. I did like the cross-fertilization of ideas and discussions from so many perspectives."

- Stakeholder comment

MCH program staff at KDHE identified stakeholders representing each of the three population groups (pregnant women and infants, children and adolescents, and children with special health care needs). The stakeholders broadly represented MCH concerns in Kansas and included family representatives, adolescents, health care providers, and program staff as well as representatives from other state agencies, local health departments, universities, not-for-profit organizations, and advocacy groups. These 77 representatives became the MCH2010 Panel of Experts. See Acknowledgements Section for a complete listing of panel members.

MCH2010 Population Workgroups

For each of the meetings, the Expert Panel divided their time between plenary sessions and workgroup sessions. Each participant was assigned to one of three workgroups:

- Pregnant Women and Infants
- Children and Adolescents
- Children with Special Health Care Needs

Each workgroup had three "staff" for the entire process:

- Facilitator
- MCH Epidemiologist or data expert
- Recorder

The workgroups used "tools", or worksheets to structure discussion, to help keep on task and to record decisions and progress for BCYF staff. Although all workgroups used the same tools, facilitators had the flexibility to modify a tool or process if they discovered something was not working well for their groups.

Timeline

Key events related to the needs assessment process are listed in the following table. Activities centered on the three stakeholder meetings, with the Planning Team preparing for the next meeting, evaluating the progress, and providing staff support to the assessment in-between meetings.

Date	**Event**
Fall, 2003	BCYF start-up planning
Spring, 2004	Project manager and facilitators on-board, potential stakeholders identified
April 27, 2004	Initial planning meeting with project manager and MCH staff
May 4, 2004	Invitation letters sent to Stakeholders
May 24, 2004	MCH2010 Planning Team met to plan Meeting #1
May-June, 2004	MCH Epidemiologists compiled and summarized MCH-related indicators and prepared detailed overview of additional indicators available
June, 2004	MCH Capacity Assessment expert on-board
June 2, 2004	Facilitator training
June 15, 2004	Meeting #1 packets sent to Stakeholders (MCH2010 Panel of Experts)
June 25, 2004	**Meeting #1 with MCH2010 Panel of Experts**
June 28, 2004	Debriefing on Meeting #1 with MCH2010 Planning Team
July 2, 2004	Meeting #1 results sent to Panel of Experts for review
July 13, 2004	Facilitator preparation for Meeting #2
July 15, 2004	Meeting #1 evaluation surveys emailed to Panel of Experts
July 19, 2004	Conference call with MCH Capacity Assessment expert
July 29, 2004	Meeting #1 evaluation results reported to Planning Team
July- August, 2004	MCH Epidemiologists analyzed and compiled additional data requested by Panel of Experts in Meeting #1, prepared data for presentation at Meeting #2
August 2, 2004	Meeting #2 packets sent to Panel of Experts
August 16, 2004	**Meeting #2 with MCH2010 Panel of Experts**
August 21, 2004	Meeting #2 evaluation results reported to Planning Team
September 16, 2004	Debriefing on Meeting #2 with Planning Team
September 24, 2004	Meeting #2 results emailed to Panel of Experts for review and comment
September 30, 2004	Facilitator training for Meeting #3 with MCH Capacity Assessment expert

Date	**Event**
September-October, 2004	Comments received from Panel of Experts and reviewed by Planning Team, BCYF staff refined list of priority needs and strategies
October 15, 2004	Meeting #3 packets sent to Panel of Experts
October 29, 2004	**Meeting #3 with MCH2010 Panel of Experts**
November 5, 2004	Meeting #3 evaluation results reported to Planning Team
November 22, 2004	Debriefing on Meeting #3 with Planning Team
December 14, 2004	Meeting #3 results emailed to Panel of Experts for review.
December 22, 2004	Final report of capacity assessment results received from MCH Capacity Assessment expert and reviewed by core Planning Team
December, 2004 - January, 2005	Final Needs Assessment Report prepared by MCH Planning Team
February, 2005	Draft Needs Assessment Report posted online for review

Meeting #1

In this section, a summary of the agenda, tools used, and progress made from Meeting #1 are presented.

Agenda

- Plenary Sessions
  - Detailed Overview of Title V and Tile V Needs Assessment
  - Data-Driven Decision Making
- MCH Population Workgroup Sessions
  - Review of Data Indicators
  - Final Selection of Key Indicators
  - Determination of Data Needed for Decision Making

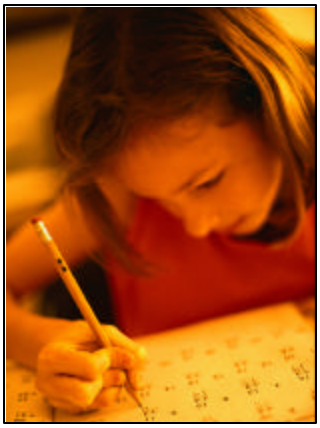
"Hearing the many and diverse issues makes me understand the extreme difficulty in prioritizing needs. It is good to see outcomes will be identified based on an analysis of available data."

- *Stakeholder comment after Meeting #1*

Tools

The Tools used in Meeting #1 are listed below, and copies are included in Appendix A.

Tool	**Task Description**
Pre-Meeting Assignment for Panel of Experts members	Review indicator list for MCH population group and determine five *most* important and five *least* important indicators based on criteria listed.
Tool #1: Data Indicator Selection	Review indicator listing and determine data indicator needs for priority selection.
Tool #2: Additional Data Needed	List additional data needs and desired stratifications.



Data

Lists of indicators by MCH population group were provided to the Panel of Experts before and at Meeting #1. Stakeholders reviewed these lists using the Pre-Meeting Assignment and Tool #1. Nationally- or state-recognized indicators with standardized definitions were chosen from the following sources:

- Centers for Health and Environmental Statistics, KDHE
- Healthy People 2010
- Health Status Indicators from MCH Block Grant
- Health Systems Capacity Indicators from MCH Block Grant
- Previous MCH Needs Assessment
- Kansas Information for Communities, KDHE
- National Outcome Measures from MCH Block Grant
- National Performance Measures from MCH Block Grant
- National Survey of Children with Special Health Care Needs, 2001
- Pregnancy Risk Assessment Monitoring System (PRAMS) data from other states (not available in Kansas)

To encourage data-driven decision making, the following information was given for each indicator, where available and applicable:

- Kansas data
- U.S. data
- Healthy People 2010 goal
- Kansas data source
- National data source
- Whether or not county-level data was available
- Comments

See Appendix B for the indicator tables.

Progress

At the end of Meeting #1, the MCH2010 Panel of Experts had an understanding of Title V, Title V needs assessment requirements, and the MCH2010 Needs Assessment process. Detailed lists of indicator needs had been developed. Although the indicators were prioritized, the lists of data needed by each of the population workgroups were extensive. The list was reviewed and revised by BCYF staff based on data availability and resource limitations. In the two months following the meeting, the MCH epidemiologists

compiled data and prepared presentations of key indicators for each Panel of Experts.

Meeting #2

In Meeting #2, the Panel of Experts reviewed key indicators, selected priorities, and suggested strategies for addressing priorities.

"Total process was well lined out and tools well chosen. Facilitator did an excellent job of listening, drawing out consensus, and moving group forward to conclusions."

- Stakeholder comment after Meeting #2

Agenda

- Plenary Session: Review Meeting #1 Results, Charge to Group for Meeting #2
- MCH Population Workgroup Sessions
    - Presentation of Key Data Indicators
    - Identify Possible Priorities
    - Select Top Priorities
- Plenary Session: Synthesize Work of Groups, Note Cross-Cutting Issues Among Workgroups
- MCH Population Workgroup Session: Suggest Strategies for Each Priority

Tools

The Tools used in Meeting #2 are listed below, and copies are included in Appendix C.

Tool	Task Description
Tool #3: Identify Possible Priorities	Select possible priority needs based on data presented.
Tool #4: Q-Sort	Sort possible needs in priority order.
Tool #5: Additional Data Needed	Suggest strategies by public health function for each priority.

Data

BCYF MCH Epidemiologists prepared data presentations and data handouts with key indicators for each group. The epidemiologist or data expert assigned to the group presented the data, which was used in priority need selection.

See Appendix D for the data presentations. (Appendix D materials are not inclusive of all data resources used at Meeting #2.)

Progress

At the end of Meeting #2, each of the workgroups had selected their top priority needs and suggested strategies to address those priorities. After the meeting, BCYF staff refined the list of priority needs (primarily wording changes to make the priority descriptions more succinct) and the strategies. The revised results were sent to the Panel of Experts and their comments were solicited on a response sheet. (See Appendix C.4 for the response sheet.) Revisions were again made to priorities and strategies after receiving feedback from the Panel of Experts.

Meeting #3

"I gained a better understanding of the demands on KDHE staff and better understanding of vast needs."

- Stakeholder comment after Meeting #3

In Meeting #3, the Panel of Experts conducted a capacity assessment using selected Capacity Assessment for State Title V (CAST-5) resources. CAST-5 is a set of assessment and planning tools designed to assist state MCH programs in examining their capacity.

The main objectives of the MCH2010 capacity assessment were:

- To enhance understanding of "capacity" and how it relates to the Expert Panel's work at Meetings 1 and 2,
- To introduce CAST-5,
- To identify the environment for addressing the priorities and strategies from the August meeting, and
- To identify specific resources that need to be developed and suggest first steps.

A more detailed discussion of the capacity assessment process and results is given in the Capacity Assessment section of this document.

Agenda

- Plenary Session: Overview of CAST-5
- MCH Population Workgroup Sessions
    - SWOT Analysis
    - Capacity Assessment

Tools

The Tools used in Meeting #3 are listed in the following table, and copies are included in Appendix E.

Tool	Task Description
SWOT Analysis	Analyze strengths, weaknesses, opportunities and threats (SWOT) by MCH population group.
Capacity Needs Worksheet	Identify and prioritize MCH capacity needs, identify resources to assist with capacity building, and determine first steps towards improvement.

Data

Draft priority and strategy results from Meeting #2 were provided as reference material. (See Appendix G.) Expert Panelists were also given a list of those strategies from Meeting #2 that could be classified as "capacity-building." (See Appendix H.)

Progress

At the end of Meeting #3, the SWOT analyses and Capacity Needs Worksheets were completed by population group. Results were sent to the Panel of Experts. Ms. Ruderman submitted a final report, which has been incorporated into the Capacity Assessment section of this document.

Next Steps

A draft report of the needs assessment process has been made available to the MCH Panel of Experts and to the general public through posting on the KDHE BCYF website at http://www.kdhe.state.ks.us/bcyf.

A summary of the next steps in the needs assessment process are given in the following table.

Timeline	Next Step
February, 2005 – April, 2005	Receive public comment on needs assessment report on website.
February, 2005 – April, 2005	KDHE BYCF staff choose performance measures to evaluate progress on priority needs over next five years.
May, 2005 – June, 2005	Modify needs assessment based on results of public comment.
July, 2005	Submit needs assessment with MCH Title V Block Grant.
August, 2005	Receive feedback from federal reviewers on needs assessment as part of MCH Title V Block Grant.
September, 2005	Make final revisions to needs assessment.
September, 2005 – 2010	Implement actions and strategies to address priority needs and monitor progress.

Strengths and Weaknesses

"The process of identifying priorities and strategies seemed concrete and practical."

- *Stakeholder comment*

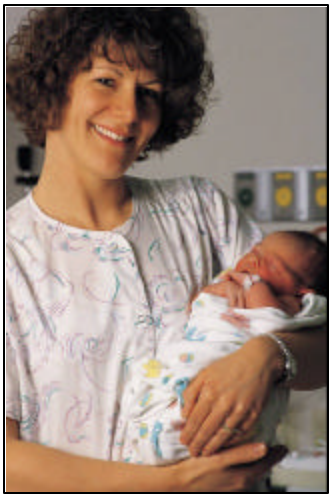
Based on MCH2010 Planning Team debriefing sessions and Panel of Expert evaluation, a summary of the strengths and weaknesses of the process are listed in the table below. (See Appendix F for copies of evaluation forms.) Overall, the process was well-received by both the Panel of Experts and BCYF staff. Most strengths identified were general to the process, while weaknesses cited were suggestions for adjusting a part of the process.

"The capacity needs tool was confusing for agencies or programs outside of KDHE."

- *Stakeholder comment*

Strengths	Weaknesses
• Good involvement of stakeholders • Diverse set of participants • Workgroups organized by three MCH populations allowed each to be well-represented in end products • Use of facilitators to guide process and tools to structure discussion was helpful • Streamlined process allowed for maximum results using the available, limited resources	• Even more family and consumer involvement would have been helpful • Some data requested by stakeholders was not readily available (e.g., cost data, child nutrition/physical activity data.) • Needed more time for discussion on some decisions. • Capacity assessment was confusing to some participants outside of state MCH Title V program.

Assessment of Needs

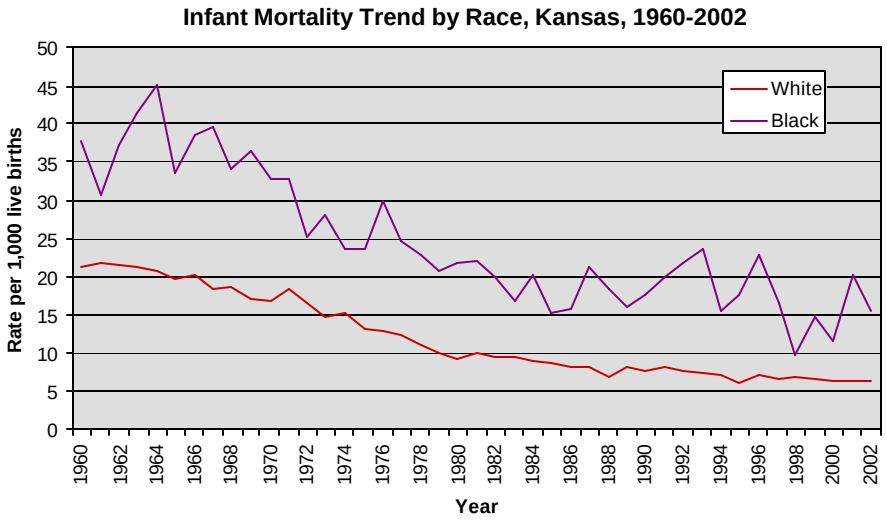


Summaries of needs assessment data presented to the MCH2010 Panel of Experts are included in Appendices B and D. Key indicators from those appendices are highlighted in this section.

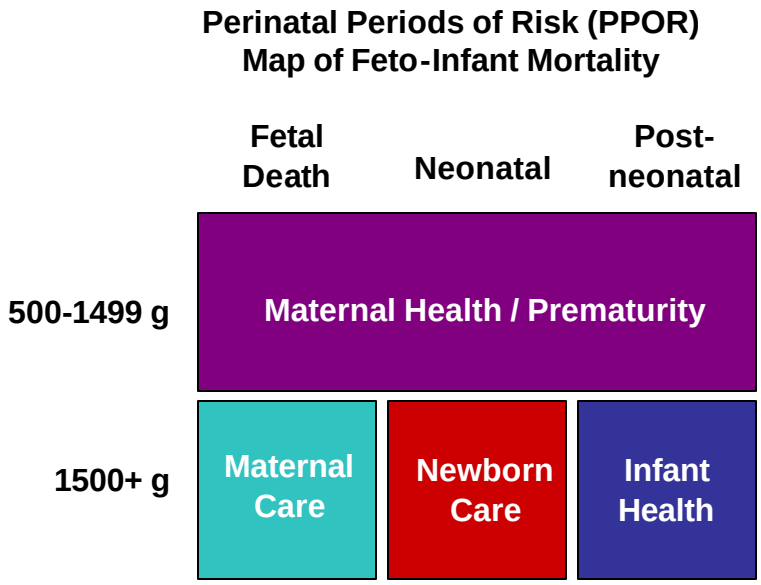
Pregnant Women and Infants

The pregnant women and infants target population was defined by the Panel of Experts as "all women of childbearing age and infants in Kansas." Infants are children under one year of age.

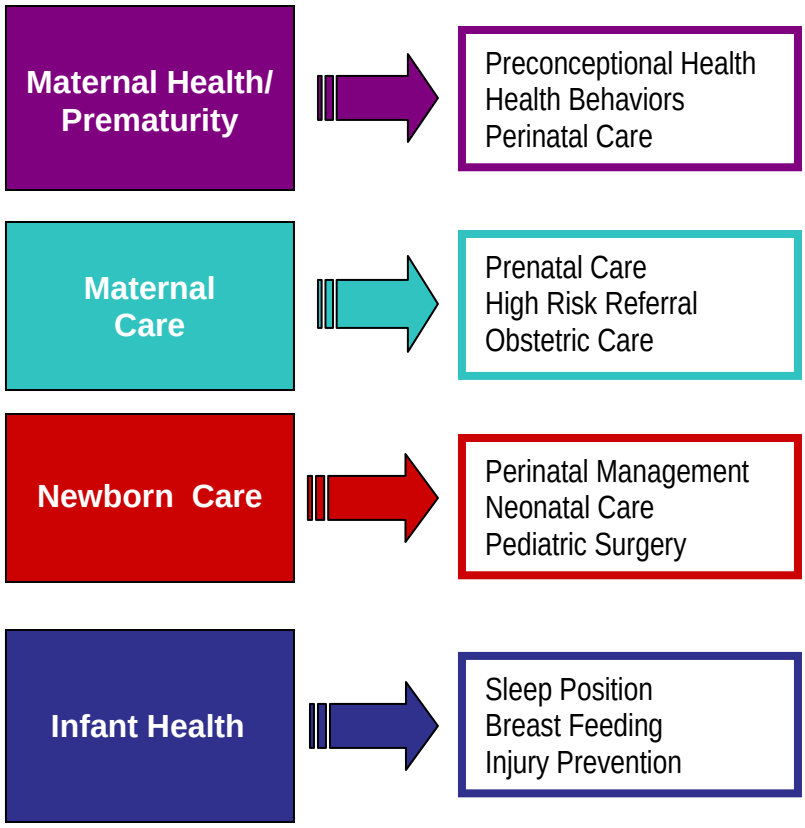
Infant Mortality. Infant mortality rates have declined steadily in Kansas over the past three decades. However, the trend has flattened in the last decade and black infant mortality is still substantially higher than white infant mortality.



Perinatal Periods of Risk. PPOR analysis is a tool to identify excess mortality and to suggest reasons for excess mortality. As such it can provide direction for programs in how best to target resources towards certain populations and which interventions would be most effective.



In the following figure, preventive actions on the right correspond to the preventive direction on the left. For example, preventive actions for maternal care include prenatal care, high-risk referral, and obstetric care.



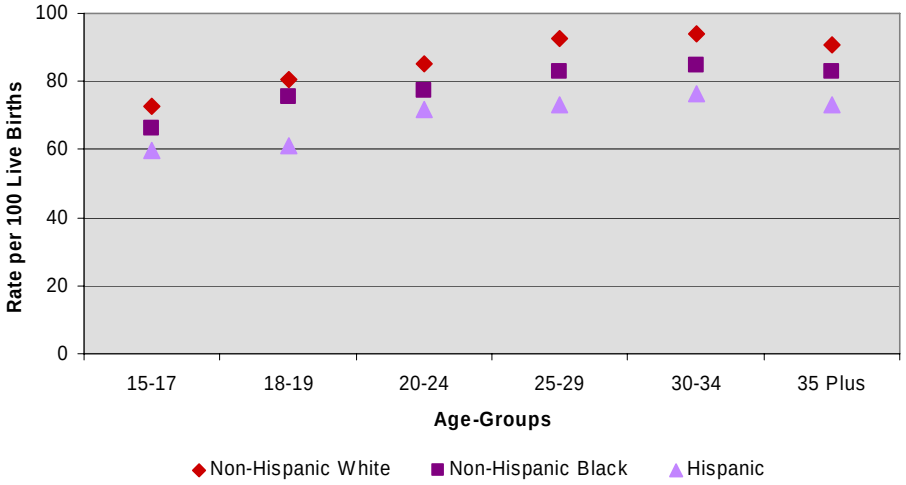
Kansas PPOR data suggest that the community interventions most likely to result in improved health outcomes for infants are those that address maternal health before, during and after pregnancy.

Prenatal Care. In Kansas in 2002, 86.1% of pregnant women started prenatal care in the first trimester of pregnancy. This is slightly higher than the national rate of 82.1%, but below the Healthy People 2010 goal of 90%. Hispanics, African-Americans, and teens had disproportionately lower rates. Geographically, early prenatal care rates are lowest in Southwest Kansas.

Percent Beginning Prenatal Care in the First Trimester
Kansas, 2002

Race	***%***		***Ethnicity***	***%***
White	86.9		Non-Hispanic	88.2
Black	78.9		Hispanic	71.1
Other	82.9			
Total: 86.1%				

Prenatal Care Began in the First Trimester by Age-Group and Ethnicity/Race

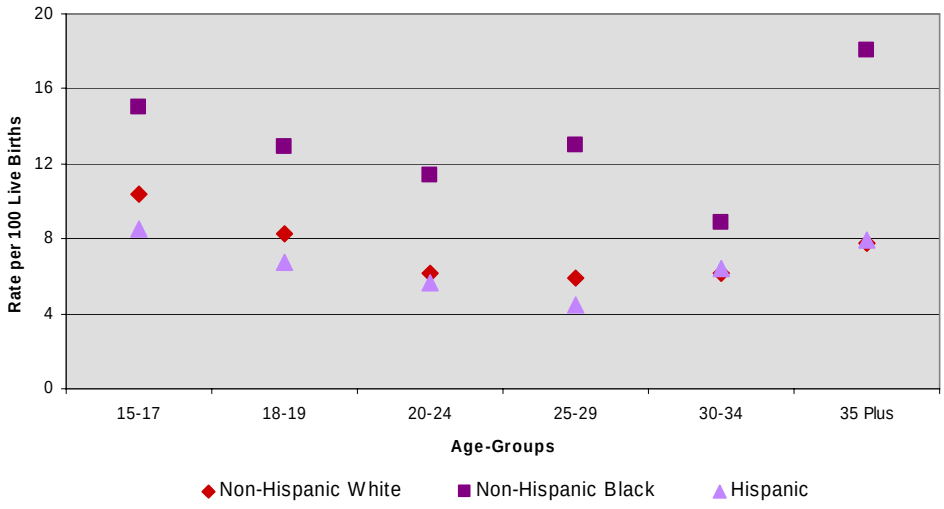


Low Birthweight. Nationally and in Kansas, low birthweight rates increased slightly over the past decade. The 2002 rate for Kansas, 7.0 per 100 live births, was slightly lower than the national average of 7.8 but above the Healthy People 2010 goal of 5.0. African American low birth rates remained disproportionately high.

Low Birthweight Rate (Less than 2500 Grams) Per 100 Live Births
Kansas, 2002

Race	*%*		*Ethnicity*	*%*
White	6.6		Non-Hispanic	7.0
Black	12.4		Hispanic	6.0
Other	5.6			
Total: 7.0				

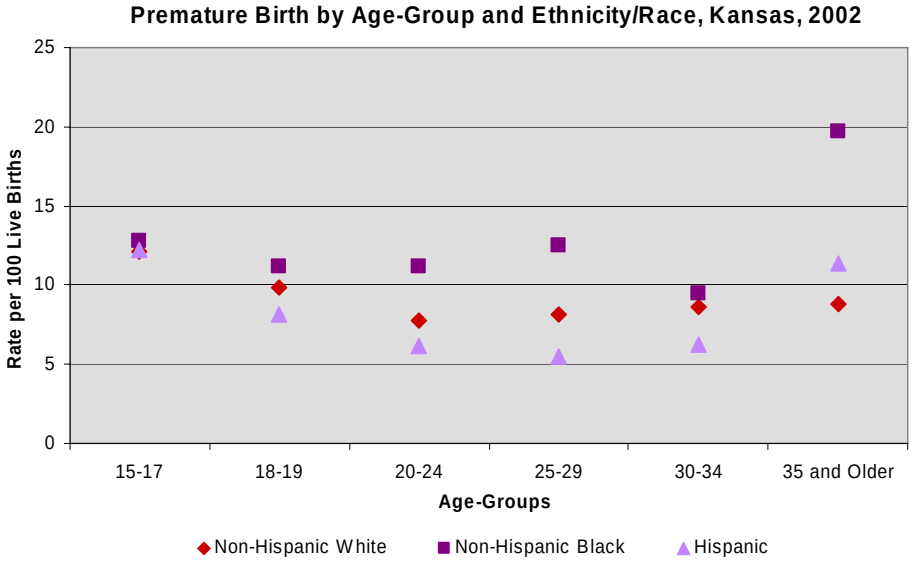
Low Birthweight by Age-Group and Ethnicity/Race, Kansas, 2002



Preterm Births. Nationally and in Kansas, the rates of preterm births (less than 37 weeks gestation) increased slightly over the past decade. Kansas performed better than the national rate, with a rate of 8.6 per 100 births versus 12.1 for the U.S. (2002). The Kansas African-American rate was substantially higher than that for other groups.

Preterm (Less than 37 Weeks) Births
Kansas, 2002

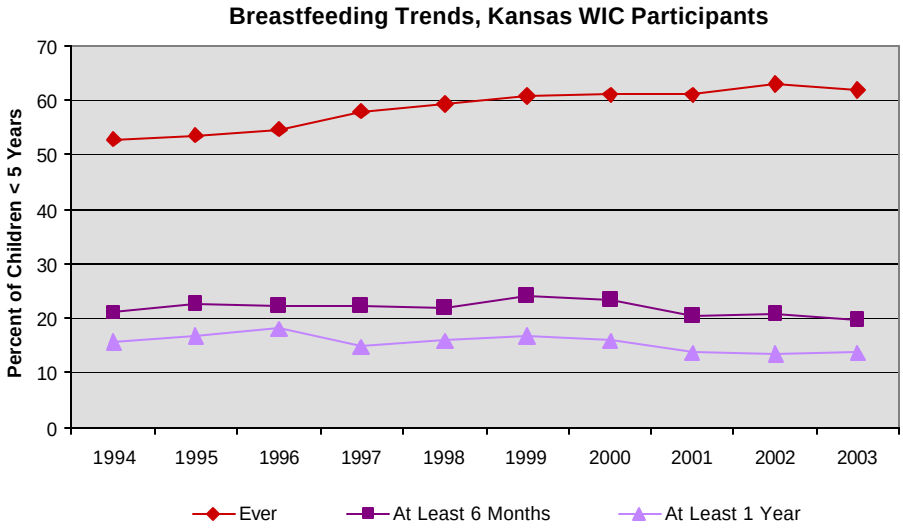
Race	*%*		*Ethnicity*	*%*
White	8.3		Non-Hispanic	8.7
Black	12.3		Hispanic	7.0
Other	7.2			
All Live Births: 8.6				



Breastfeeding. Breastfeeding data for the Kansas population is available through the Ross Labs Mothers Survey and also through the Kansas WIC Program (participants only). For WIC participants, the percent "ever" breastfed increased slightly over the past decade, while the percent breastfeeding at 6 months and at 1 year has been relatively level.

Breastfeeding among WIC Participants x Race/Ethnicity

Race/Ethnicity	*% Ever Breastfed*	*Breastfed At Least 6 Months*	*Breastfed At Least 12 Months*
White, Non-Hispanic	64.0	19.7	13.8
Black, Non-Hispanic	47.0	11.6	8.1
Hispanic	71.3	33.5	20.6
American Indian	66.3	18.1	11.5
Asian	51.0	20.3	19.9



Additional Findings. Selected other pregnant women and infant needs assessment findings are summarized in the following table.

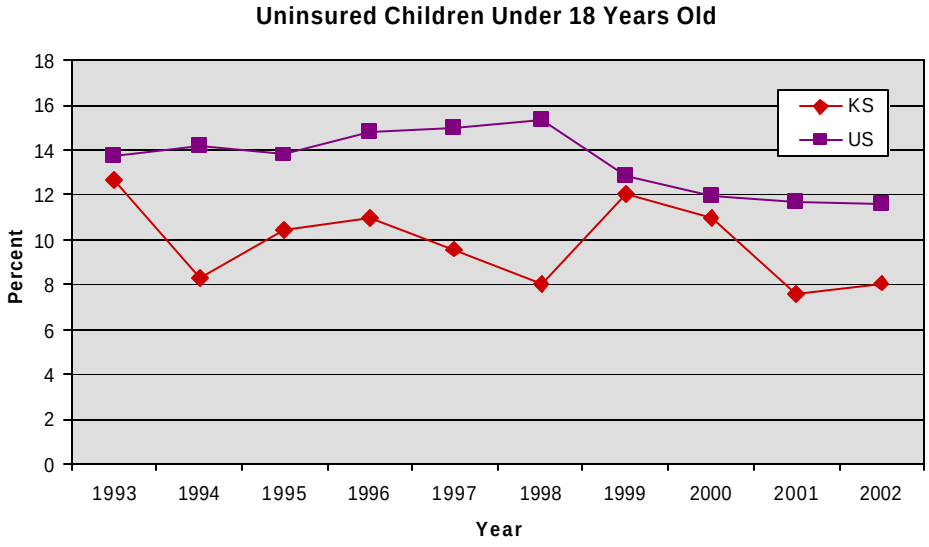
Issue	**Summary Findings**
Smoking During Pregnancy	• In Kansas, 12.5% of mothers reported smoking during pregnancy (certificate of live births, 2002) • Kansas data is slightly higher than the national average of 11.4%. Nationally the trend has been decreasing over the past decade. • The Healthy People 2010 target is ≤ 1% of women smoking during pregnancy.
Alcohol Use During Pregnancy	• Based on PRAMS (Pregnancy Risk Assessment Monitoring System) data from seven states, women aged ≥ 35 years, non-Hispanic women, women with more than a high school education, and women with higher incomes reported the highest prevalence of alcohol use during pregnancy. • The Healthy People 2010 target is ≤ 6% of women using alcohol during pregnancy.

Issue	**Summary Findings**
Postpartum Depression	• Based on PRAMS data from seven states, 7.1% of women reported severe depression after delivery and more than half reported low to moderate depression. • Also based on the PRAMS data, women under age 20 years, African American women, women with fewer than 12 years of education, Medicaid recipients, women delivering low-birth-weight babies, and those experiencing physical abuse during pregnancy were more likely to report severe depression.
Congenital Anomalies	• Nationally and in Kansas, congenital anomalies is the leading cause of infant mortality. • In 2002, there were 63 infant deaths due to congenital anomalies, accounting for 22% of all infant deaths.
Sudden Infant Death Syndrome (SIDS)	• In Kansas in 2001, there were 36 infant deaths classified as SIDS. • The Healthy People 2010 target for putting infants to sleep in the back position, a preventive measure for SIDS, is 70%.
Disparities	• Racial and ethnic disparities were evident in several indicators (low birthweight, infant mortality, prenatal care, preterm births, breastfeeding, etc.)

Children and Adolescents

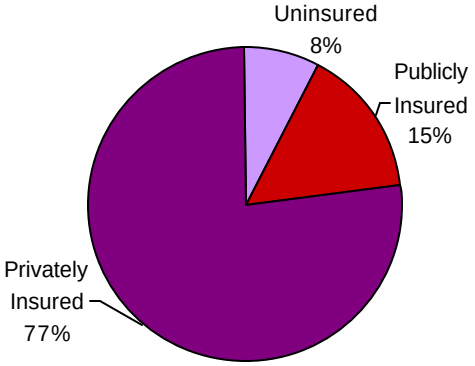
The children and adolescents target population was defined by the Expert Panel as "all children and adolescents in Kansas." The MCH Title V definition of a child: child from first birthday through twenty-first year.

Uninsured Children. In 2002, an estimated 8.1% of Kansas children under 18 were uninsured, compared to 11.6% nationally (U.S. Census Bureau, Current Population Survey).

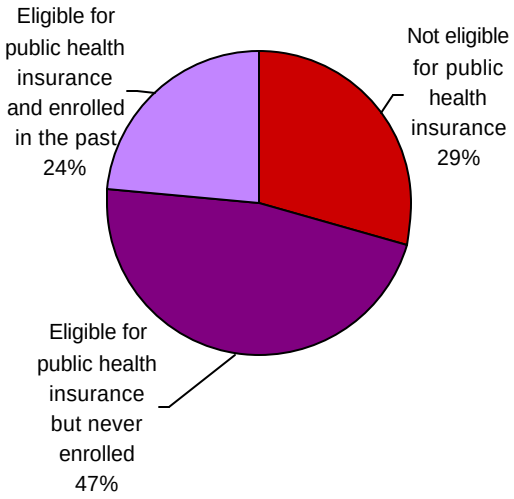


According to a statewide survey conducted in 2001, 15% of children under age 19 were insured through public insurance. Among children who were uninsured, seven-in-ten were eligible for public health insurance but not currently enrolled (Kansas Health Institute, 2003).

Distribution of Kansas Children by Insurance Status, 2001 Children Under 19 Years Old

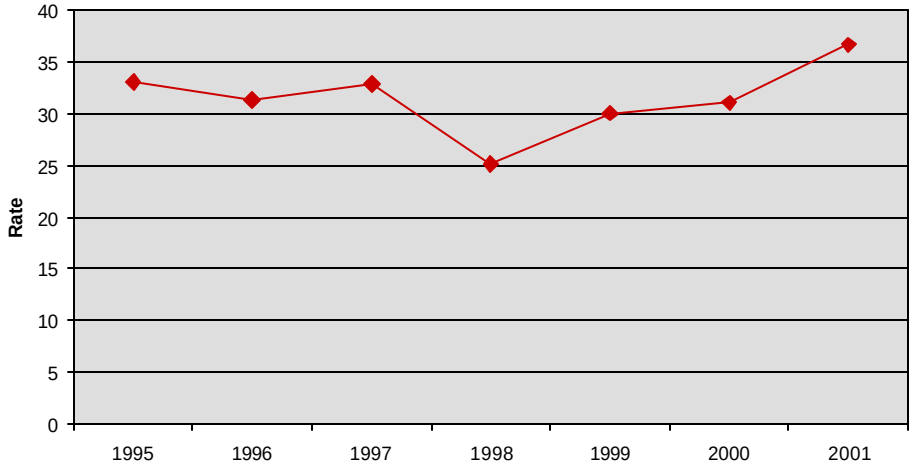


Distribution of Uninsured Children in Kansas by Eligibility and Enrollment in Public Health Insurance, 2001 Children under 19 years old



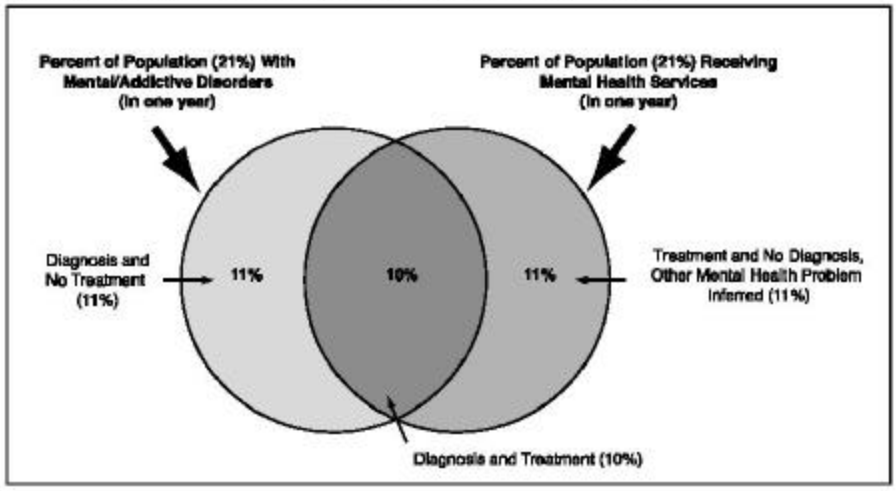
Asthma. Nationally, 5.8% of children have had an asthma attack in the past 12 months, and 12.2% of children have been diagnosed with asthma. In Kansas, the rate of asthma hospitalizations for 1 to 4 year-olds has been increasing over the past four years. The 2001 rate per 10,000 population for white children was 27.5 compared to 71.2 for African American children.

Trend in Asthma Hospitalizations Per 10,000 Population Ages 1 Through 4



Mental Health. Nationally, children's mental health/addictive disorders continues to be an emerging issue. According to the Surgeon General's report on mental health, 21% of children have mental/addictive disorders, and appropriate, evidence-based diagnosis and treatment needs to be improved (1999).

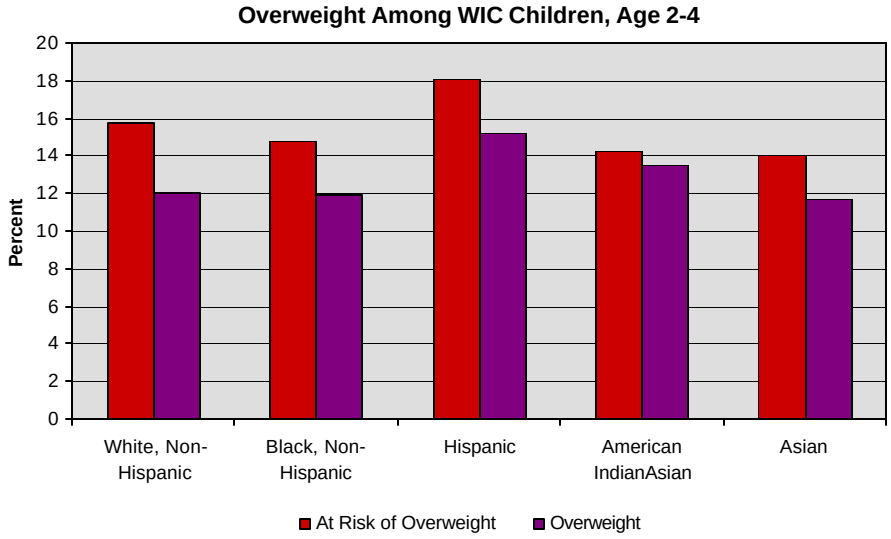
Figure 2-6a. Annual prevalence of mental/addictive disorders and services for children



Children's Behavioral/mental health issues can be identified as early as infancy. Child Care providers and others can assist in early identification.

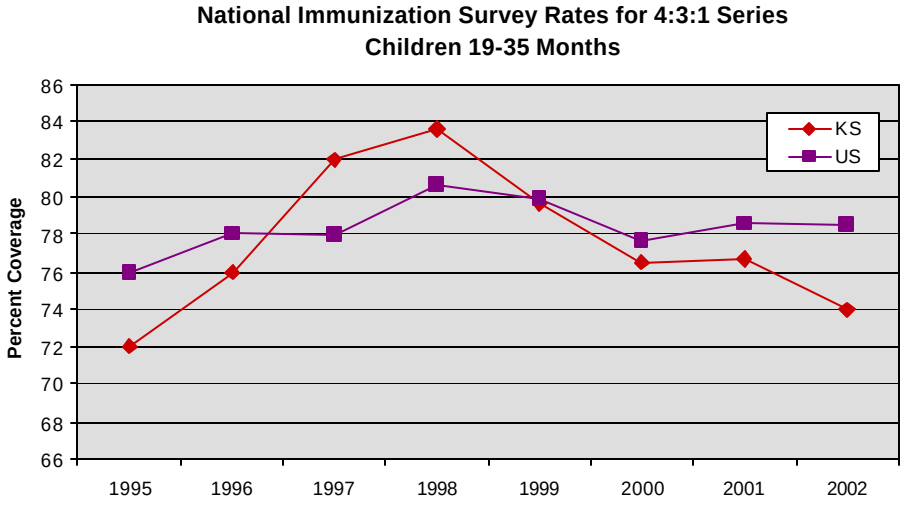
Overweight. An estimated 11% of Kansas adolescents are overweight, and 14% are at risk of becoming overweight (Kansas Youth Tobacco Survey, 2002-2003).

Pediatric Nutrition Surveillance Data (for the low-income WIC population) among children aged 2 to 4 years, showed 16% at risk for becoming overweight and 13% overweight (2003). Hispanics are at greatest risk.

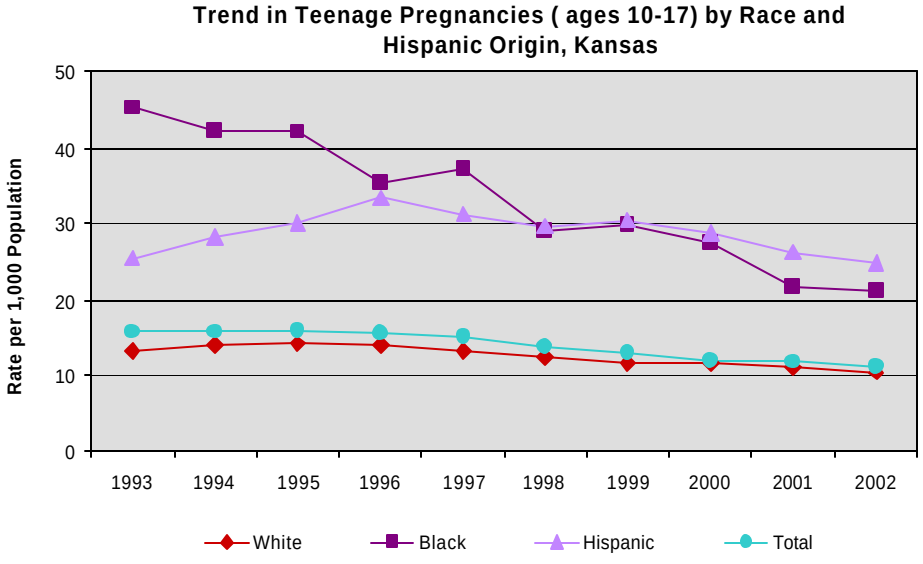


Immunization. Kansas 2002 immunization rates for the 4:3:1 combination (DTP4, Polio3, and MMR1) were slightly below that of the national average (74.0% versus 78.5%). Rates have been declining in Kansas in the past five years (National Immunization Survey).

Recent data analysis by the Kansas Health Institute attributes the lower rates for Kansas to delays in Kansas children receiving the 4th dose of DTP. As an action step, private providers have agreed to step up the administration schedule.



Teen Pregnancy. The teen pregnancy rate for Kansas and for the U.S. has been declining over the past decade. Of note, the African American teen pregnancy rate has decreased over 50% in the past decade.



Additional Findings. Selected other children and adolescent needs assessment findings are summarized in the following table.

Issue	**Summary Findings**
Children in Poverty	• In 1999, 12% of Kansas children were living in poverty. • Southeast Kansas, certain western Kansas counties, Geary county and Wyandotte county had highest rates of children in poverty.
Suicide	• In Kansas, suicide was the second leading cause of death for adolescents aged 15 to 24 years (1998-2002). • The Kansas adolescent suicide death rate is higher than the national average: 15.2 per 100,000 population versus 9.9 nationally (2001).
Illegal Drugs	• Nationally, 22% of students in grades 9 through 12 had used marijuana in the past 30 days, and 4.1% had used a form of cocaine in the past 30 days, and 7.6% had used methamphetamines one or more times during their lifetime (CDC, 2003).
Alcohol Use	• Nationally, 45% of students in grades 9 through 12 drank one or more drinks of alcohol in the past 30 days, and 12% drove after drinking alcohol in the past 30 days (CDC, 2003).
Tobacco Use	• In Kansas, 8% of youth in grades 6 through 8 and 26% of students in grades 9 through 12 currently smoke cigarettes (Kansas Youth Tobacco Survey, 2000).
Oral Health	• The prevalence of untreated decay in third graders in 11 states ranged from 16.2% to 40.2% (Association of State and Territorial Dental Directors, 2003-2004). In Kansas, 25% of third graders have active dental decay (Smiles Across Kansas 2004).
Unintentional Injuries	• Nationally and in Kansas, unintentional injuries are the leading cause of death for children and adolescents over age 1. • The hospital discharge rate for unintentional injury in Kansas has been increasing slightly over the past five years.

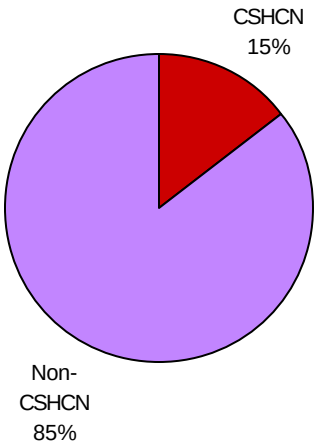
Children with Special Health Care Needs

The Children with Special Health Care Needs (CSHCN) target population was defined by the Expert Panel as "all children with special health care needs in Kansas." Children with special health care needs are defined as "those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally."

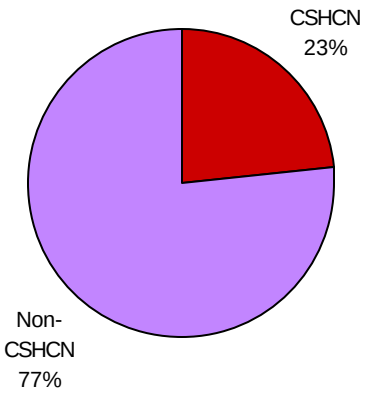
Unless otherwise noted, the source of data in this section was the National CSHCN Survey (2001). Because of the difficulty of including the range of factors that might place children at increased risk for special health needs, the population of children "at risk" was excluded from the survey and results presented here.

Prevalence. An estimated 15% of Kansas children aged 0 to 17 had special needs, which was slightly higher than the percent of children nationally, 13% (2001). Nearly one-quarter of Kansas households with children had a special needs child.

Prevalence of CSHCN in Kansas: Persons (2001)



Prevalence of CSHCN in Kansas: Households (2001)



Considering the demographics of CSHCN, older children in Kansas and nationally were twice as likely as younger children to have a special need (17.7% of 12 to 17 year-olds versus 8.4% of 0 to 5 year-olds). Kansas boys were more likely than girls to have special needs (16.8% versus 12.6%). By race/ethnicity, Hispanic children were least likely to have a special need (9.1% of Hispanics versus 15.4% of White, Non-Hispanics). There was not a significant difference in prevalence between White Non-Hispanic and African American Non-Hispanic children.

CSHCN Indicators. A summary of CSHCN indicators is presented in the table below. In general, Kansas CSHCN faired slightly better than U.S. CSHCN.

Indicator Category	**Indicator**	**Kansas**	**US**
Child Health Status	Percent of CSHCN whose health condition consistently and often greatly affect their daily lives	20%	23%
Child Health Status	Percent of CSHCN with 11 or more days of school absences due to illness	10%	16%
Health Care Coverage	Percent of CSHCN without insurance at some point during the past year	9%	12%
Health Care Coverage	Percent of CSHCN currently uninsured	4%	5%

Indicator Category	Indicator	Kansas	US
Health Care Coverage	Percent of currently insured CSHCN with coverage that is not adequate	31%	34%
Access to Care	Percent of CSHCN with one or more unmet needs for specific health services	19%	18%
Access to Care	Percent of CSHCN without a usual source of care (or who rely on the emergency room)	7%	9%
Access to Care	Percent of CSHCN without a personal doctor or nurse	6%	11%
Family-Centered Care	Percent of CSHCN without family-centered care	30%	33%
Impact on Family	Percent of CSHCN whose families experienced financial problems due to child's health needs	24%	21%
Impact on Family	Percent of CSHCN whose health needs caused family members to cut back or stop working	28%	30%
Transition to Adulthood	Percent of youth with special health care needs who will receive the services necessary to make transitions to all aspects of adult life.	5%*	6%

* Due to small sample size, estimate does not meet the National Center for Health Statistics standard for reliability or precision.

Children Served by Condition. A summary of children served by the KDHE CSHCN program (FY 2004) for selected conditions is given in the below table.

Condition	Children Served by KDHE CSHCN Program
Cerebral Palsy	274
Cleft Lip/Cleft Palate	178
Spina Bifida	76
Cardiology Special Needs	266

Providers by Specialty. The number of KDHE CSHCN providers by specialty is listed in the following table. (Note: All providers are not necessarily currently providing care to children through the KDHE CSHCN program.)

Specialty	Number of KDHE CSHCN Providers
Primary Care	405
Dental	193
Pediatric Cardiologists	26

Priority Needs

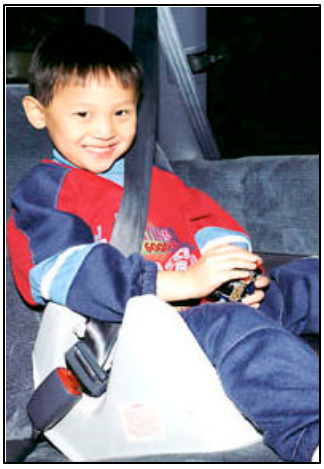
The resulting Kansas MCH2010 priority needs for 2005 through 2010 and brief justifications for their selection are given below.

Priority Need	Why Chosen
Pregnant Women and Infants	
Increase early and comprehensive health care before, during, and after pregnancy	- Among factors within the influence of the MCH system, most effective for improving health outcomes for mothers and infants - Kansas prenatal care rates improving and above national average but below Healthy People 2010 goals and significant racial/ethnic and geographic disparities present
Reduce premature births and low birthweight	- Rates increasing slightly statewide and nationally - Relationship (positive or negative) with other issues of concern: infant mortality, prenatal care, risk behaviors of pregnant women (smoking, drug abuse), access to appropriate medical care for high-risk mothers and newborns
Increase breastfeeding	- Rates well-below Healthy People 2010 goals, especially at 6 and 12 months of age, and for low-income women - Focus on increasing the incidence and duration of breastfeeding (American Academy of Pediatrics [AAP] recommends 6 months exclusive breastfeeding)
Children and Adolescents	
Improve behavioral/mental health	- Behavioral health a priority in previous five years; more progress needed - Potential for improved linkages and relationships between MCH system and behavioral/mental health providers; need for early identification - Relationship with other issues of concern: suicide, drug and alcohol abuse, relationship violence
Reduce overweight	- Increasing problem nationally; limited reliable Kansas data - Strong association with other issues of concern: physical activity, nutrition, chronic diseases, excessive usage of television/computer/video games
Reduce injury and death	- Focus of priority is *preventable* injury and death, especially unintentional and intentional injuries - Unintentional injury -the leading cause of death for all age groups (ages 1-24 years) and the fifth leading cause for infants - Intentional injury - homicide is among the leading 10 causes of death for children/adolescents and suicide is among leading 3 causes of death for adolescents

Priority Need	Why Chosen
Children with Special Health Care Needs (CSHCN)	
Increase care within a medical home	- Unmet access-to-care needs evident from data - Coordinated, family-centered care within a medical home is the key to improved health outcomes
Improve transitional service systems for CSHCN	- Strong need evident from data and reports from providers, consumers, and BCYF staff; only 5% of Kansas CSHCN received services necessary to make transition to all aspects of adult life per national survey
Decrease financial impact on CSHCN and their families	- Substantial need evident from coverage and impact-on-family data indicators and Panel of Experts experience

Three additional focus issues were chosen. Systems are in place to address two of the issues listed below, oral health and teen pregnancy. One issue, asthma, needs a coordinated, statewide public health response. Every effort will be made to maintain or improve efforts in these focus areas given capacity and resources.

Focus Area	Why Chosen
Reduce teen pregnancy and sexually transmitted diseases	- Teen pregnancy rates declining in Kansas, but racial/ethnic and geographic disparities exist and vigilance necessary to continue trend
Improve oral health	- Priority from previous five years; progress made, but important that progress continues - Additional consumer and provider education necessary - Lack of access, particularly among low income, and oral health status troubling
Improve asthma diagnosis and treatment	- Focus on *evidence-based* diagnosis and treatment; evidence-based treatments available to greatly improve quality of life; providers and consumers need to be better educated - Kansas higher than national average, and rates higher in rural areas - No coordinated, statewide effort in Kansas as with other key issues



Potential Strategies

The Expert Panel identified potential actions or strategies to address each priority need by following approaches:

- Provide services directly
- Contract with others to provide services
- Regulate the activity
- Educate public, providers, etc.
- Systems development
- Data system improvement

The resulting potential strategies and action steps are given in Appendix H. Some of the strategies suggested are feasible and will be acted upon; others are not feasible or practical at this time. All were helpful in generating ideas towards approaches to improving the health of Kansas women, infants, and children. These are working documents which will be used and revised by BCYF staff during the next five years.

One cross-cutting strategy, reduce racial and ethnic disparities, was added to address disparities evident in several priority needs.

Capacity Assessment

Background

A critical component of the Title V needs assessment process is the assessment of organizational and system-wide capacity to carry out program and policy activities and meet goals for success.

Capacity Assessment for State Title V (CAST-5) is a set of assessment and planning tools designed to assist state MCH programs in examining their organizational capacity to carry out essential maternal and child health roles and activities. CAST-5 is an initiative of the Association of Maternal and Child Health Programs and the Johns Hopkins University Women's and Children's Health Policy Center, in partnership with the Health Resources and Services Administration's Maternal and Child Health Bureau.

The complete set of CAST-5 tools provide a structure for assessing performance of public MCH program functions in the context of program mission and goals, political, social, and economic context, and population health needs. (The full set of CAST-5 tools and a variety of related resources are available at http://www.amchp.org/cast5.) Specific organizational resources

necessary for optimal performance are identified and form the basis for strategic thinking about capacity-building opportunities. For the purposes of MCH2010, an abridged set of CAST-5 tools was selected for Meeting #3 and modified slightly to fit the Kansas needs assessment process.

Defining Capacity

Capacity can be defined simply as "the ability to do something" (*American Heritage Dictionary*, 1982). In CAST-5, capacity is categorized as 1) structural resources, 2) data/information systems, 3) organizational relationships, and 4) competencies and skills.

- **Structural resources** are financial, human, and material resources; policies and protocols; and other resources held by or accessible to the agency that form the groundwork for the performance of core functions.
- **Data/information systems** are technological resources enabling state of the art information management and data analysis.
- **Organizational relationships** are partnerships, communication channels, and other types of interactions and collaborations with public and private entities.
- **Competencies and skills** refer to the knowledge, skills, and abilities of KDHE staff and their partners in the MCH system.

MCH2010 Capacity Assessment

A schematic of the links between the steps in the MCH2010 capacity assessment process is given below.

Kansas MCH2010 Capacity Assessment Process

Where do we want to be? Where are we now?	→	MCH 2010 Meetings 1 and 2 *Review of MCH indicators* *Top population health priorities* *Potential strategies (starting point)*
What will help or hinder our progress?	→	SWOT Analysis *Identification of strengths, weaknesses, opportunities, and threats related to addressing population health priorities*
What do we need to get there?	→	Capacity Needs Tool *Identification of MCH system and organizational resources needed to implement strategies and address population health priorities*
How do we get it?	→	Recommended "First Steps" and follow up by KDHE *Suggested capacity building activities/first steps to be integrated into KDHE planning activities*

Broadly speaking, there were three steps in the capacity assessment process:

1. Identify strengths, weaknesses, opportunities, and threats to addressing priority health needs;
2. Identify specific system capacities and organizational resources needed to address priority health needs and implement related strategies; and
3. Identify key stakeholders for building the needed capacity and "first steps" for KDHE.

The anticipated end products of these steps were a broad picture of the environment for the state MCH system, conceptualized as cross-cutting strengths, weaknesses, opportunities, and threats for all three workgroups (step 1); a list of system capacity needs ranked by level of importance (step 2); and, for each system capacity need, a list of recommended first steps and stakeholders (step 3). Taken together, these products would form a guiding framework for KDHE efforts to facilitate capacity building in the MCH system and a basis for realistic and strategic planning.

Identification of Strengths, Weaknesses, Opportunities, and Threats

The capacity assessment began with an assessment of factors that could help or hinder the MCH system's progress toward addressing priority health needs in the state. Workgroups used an adapted CAST-5 SWOT Analysis tool to outline strengths, weaknesses, opportunities and threats (SWOT) related to carrying out the strategies and addressing the priorities they identified at the August 2004 meeting. The full Expert Panel then reconvened for workgroup reports. Complete workgroup SWOT results are attached as Appendix I.

A number of cross-cutting strengths, weaknesses, opportunities, and threats were identified and discussed:

Cross-Cutting Strengths

- Many data sets available
- Excellent coalition activity
  - Kansas Action for Children
  - Kansas Association for the Medically Underserved
  - Children's Cabinet
  - Others
- Good MCH staff at KDHE with good working relationships with partners

- "Team players" on a variety of issues
- Increased interagency collaboration
- Governor supportive of public health efforts
- Increased visibility and awareness of health issues in general and specifically with CSHCN
- Increased visibility of issues related to serving diverse populations

Cross-Cutting Weaknesses

- Lack of public and provider awareness
  - Mental health stigma and misconceptions
  - Healthy lifestyles
  - Issues for children also issues for parents (harder to impact)
  - Lack of clarity around medical home terminology
  - Awareness of appropriate training for health professionals
- Data/technological limitations
  - Limited monitoring ability
  - Unable to share data across agencies
  - Lack of trained people to maintain and use the technological resources
  - Not enough analytic capacity
- Lack of bilingual/Spanish-speaking services
- Could be better communication and collegiality in collaborative efforts
- Improvements in system capacity are inconsistent across state
- Not serving rural populations as well as could
- Training needs (e.g. CSHCN)

Cross-Cutting Opportunities

- Education and social marketing opportunities
  - Marketing of medical home concepts
  - Education on contractual requirements in the consortium system
  - Education on the Kansas Nutrition Network
- Have resources in place that could be better utilized and understood
  - Universities and graduate students
  - Parish nurse system
  - Consortium system for mental health services
  - Use of technology for education
- Data collection and analysis opportunities
  - Expand on Kids Count
  - Use school data on height and weight
  - Other opportunities exist as well

- Work with legislators

Cross-Cutting Threats

- Easy to lose sight of "big picture" and goals in light of day-to-day work
- Bureaucratic process takes lots of time
- Geographic and financial disparities
- Fiscal constraints, lack of personnel—impact leadership capacity
- Changes in leadership within agencies
- Political climate (ideology over science, polarized society, hard to discuss issues)
- Public and private fear of the unknown and resistance to change
- Decreased insurance coverage
- Culturally-based desire for independence, less government involvement
- Lack of buy-in at social and political levels (apathy)

Assessment of MCH System and KDHE Resources and Capacity Needs

Following discussion of these environmental factors, the workgroups met again to identify specific resources needed in the MCH system to carry out strategies aimed at addressing priority population health needs. Some of the strategies the workgroups had identified at the second MCH 2010 meeting are in and of themselves capacity-building strategies. Workgroups were encouraged to incorporate those capacity-building strategies into the list of capacity needs they would generate at the capacity assessment meeting. (See Appendix H for the capacity-building strategies.)

Using the CAST-5 Capacity Needs Tool, the workgroups assessed the status of structural resources, data/information systems, organizational relationships, and competencies/skills in the Kansas MCH system. Summarized results are listed below. More detailed summaries by population workgroup are included in Appendix J.

Capacity Strengths

A number of strong resources were identified in the workgroup discussions of the Capacity Needs Tool:

- Communication channels between MCH programs/agencies and consumers/communities (e.g., listservs, newsletters)

- Strong communication and data translation skills, especially at the state level
- Good data/analysis skills
- Good maternal and child health content knowledge
- Experience and expertise in working with and in communities
- Good understanding of the state context
- Access to national data sources
- Active coalitions which influence policymaking
- Linkage with professional groups such as the Kansas Perinatal Association
- Effective public-private agency collaborations and partnership mechanisms
- Relationships with state policymakers
- Mechanisms for accountability and quality assurance are improving
- Good relationships across many KDHE agencies/programs
- Mechanisms for state-local linkages in place (e.g., Kansas Association of Local Health Departments)

Capacity Needs

Participants identified many areas of capacity that could be developed or enhanced in order to better serve children and families in Kansas. Many of these capacities already are in place in the Kansas MCH system but would benefit from further improvement and/or sustained attention. The capacity needs discussions elicited many ideas for capacity-building opportunities and served as the basis for preliminary brainstorming about instrumental stakeholders and "first steps."

Capacity needs rating "high" importance and/or listed by more than one workgroup included:

Structural Resources

- Funding (e.g., for communications coordinator position)
- Authority (e.g., statutory change to allow implementation of Pregnancy Risk Assessment Monitoring System [PRAMS])
- Communication channels between consumers and high-level policymakers
- Improved communication with businesses and private providers
- Improved links to academics
- Partnership mechanisms
- Improved access to up-to-date science, policy, and programmatic information

- Workforce capacity structures and assessment at local level
- State-level board certified lactation consultant
- Formalized accountability and quality assurance mechanisms
- Formalized plans for dissemination of quality standards (e.g., guidelines for perinatal care published in AAP/ACOG's Blue Book, Baby Friendly Hospital Initiative)
- Strengthened accountability for local level outcomes/measures

Data/Information Systems

- Improved data monitoring systems
- Access to timely program and population data
- Supportive environment for data sharing
- Adequate data infrastructure
- Access to insurance data

Organizational Relationships

- Relationships among state agencies (not just within KDHE)
- Relationships with state and national entities enhancing analytical and programmatic capacity
- Relationships with businesses (e.g., for funding opportunities)
- Relationships with local policymakers
- Relationships among KDHE programs/divisions (e.g., for FIMR [Fetal and Infant Mortality Review])
- Relationships with insurers and insurance oversight stakeholders
- Relationships with local providers of health and other services
- Strengthened state-local linkages and understanding around MCH issues

Competencies/Skills

- Communication and data translation skills at the local level
- Management and organizational development skills (e.g., continuing education, cross-training)
- Improved skills with non-English speaking populations

For a full discussion of MCH Capacity by level of the MCH Pyramid, refer to MCH Block Grant Application https://performance.hrsa.gov/mchb/mchreports.

Overall Key Themes and Recommendations

Several overall themes were evident in the SWOT and Capacity Needs results:

- There is a strong base of collaborative relationships to build on. There are many opportunities to capitalize on existing resources and relationships (e.g., expand on available data sources, enhance partnerships with university faculty and students, enhance use/understanding of mental health consortium system, etc.).
- There are inconsistencies in capacity across regions of the state and between the state and local levels (particularly with regard to data analysis and translation).
- The capacity to serve non-English speaking consumers is inadequate.
- Communication channels could be expanded to underutilized sectors (e.g., businesses, private providers). Enhanced communication could assist in laying the groundwork for greater data sharing (e.g., access to insurance data) and for potential funding opportunities.
- The system could benefit from formalized quality assurance and accountability mechanisms at the state and local levels. This process could include examination of workforce capacity and aligning state and local job descriptions and training opportunities with strategic infrastructure needs.
- Challenges to moving forward with capacity-building activities include the difficulty of carving out time from daily work to focus on infrastructure building, getting around bureaucratic barriers to change, and the current fiscal climate.

It is important to acknowledge another significant factor in moving forward with capacity development based on the outcomes of the October 29, 2004 capacity assessment meeting. The capacity assessment was focused broadly on the MCH system as a whole, reflecting the commitment of BCYF leadership to operating within a system development perspective, as opposed to a "silo" mentality. Because many system capacities rest on the resources and capacities of individual system partners, in some cases KDHE has a limited ability to effect capacity development *on a system level*. In these cases, BCYF may need to identify *agency-specific* capacity-building activities that will nonetheless benefit the entire MCH system. In fact, many of the capacity needs identified by the workgroups already are oriented toward the health agency and can serve as the basis for capacity development plans undertaken by

BCYF. BCYF leadership may also identify other capacity needs for which the BCYF has the resources necessary to spearhead broader, system-level capacity building activities.

Recommended Next Steps

In the next few months, it will be important to capitalize on the engagement of stakeholders in the MCH 2010 needs assessment process and to keep participants informed about use of the needs assessment results. It is critical that participants see some tangible actions resulting from their work.

The CAST-5 consultant recommended that the Bureau for Children, Youth and Families implement the following short-term next steps within the next six months.

- Clarify the role of BCYF leadership in advancing the areas of ***system-level*** need identified by capacity assessment participants.
    - Draft specific workplans for initiating this system capacity development work, drawing from the October 29 meeting results (e.g., first steps, instrumental stakeholders).
- Form an ad hoc work group to *examine workgroup results for high priority areas of* ***KDHE organizational capacity development.*** Consider drafting a BCYF capacity development action plan.
    - Identify a clear process for obtaining input on this action plan from other KDHE/BCYF staff and other relevant stakeholders.
    - Identify two to three "winnable" and "doable" goals/objectives that can be accomplished in the next year.
    - Include short and long-term objectives, clearly-defined activities, timeline targets for tasks specified, and clearly defined roles for staff.
    - Identify ways that BCYF will measure success in implementing the action plan.
    - Finalize and disseminate the action plan to KDHE staff and external stakeholders and clearly communicate next steps for its implementation.
    - Integrate the action plan into Title V needs assessment reporting and related planning activities.

"Communicate with stakeholders periodically regarding status of grant and progress against approved grant over next few years."

- Stakeholder suggestion

The consultant recommended that BCYF reconvene the MCH2010 Panel of Experts, or a subgroup of participants, within one year to assess progress toward meeting short-term objectives and activities outlined in the BCYF-specific action plan and system-level capacity development plan(s).

The consultant also recommended that BCYF leadership re-examine the full set of CAST-5 Tools and consider using all or some of the CAST-5 process as the basis for BCYF program performance assessment. The CAST-5 SWOT and Capacity Needs Tools can be used to re-examine the areas of capacity highlighted in the MCH2010 process and assess progress toward internal capacity building.

Looking Ahead

Needs assessment and the identification of potential strategies are only the *first* steps in a cycle for continuous improvement of maternal and child health.

We invite you to join us on this journey of enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Acronyms

AAP: American Academy of Pediatrics

ACOG: American College of Obstetricians and Gynecologists

BCYF: Bureau for Children Youth, and Families

CAST-5: Capacity Assessment for State Title V

CSHCN: Children with Special Health Care Needs

FY: Fiscal Year

KDHE: Kansas Department of Health and Environment

MCH: Maternal and Child Health

MCH2010: Kansas Maternal Child Health Needs Assessment, covering the period 2005 to 2010

PRAMS: Pregnancy Risk Assessment Monitoring System

SWOT: Strengths, Weaknesses, Opportunities, Threats

TVIS: Title V Information System, https://performance.hrsa.gov/mchb/mchreports

WIC: Women, Infants, and Children

Public Comment

Public Comment #1

"I have read the draft and am very pleased with the document. It addresses all the pertinent components of process and identification of the consensus needs per the meetings."

- First Guard

Public Comment #2

"Looks impressive! Will you be sending out the final version at a later date? Thanks."

- Wyandotte County Health Department Representative

Public Comment #3

Kansas Academy Of Family Physicians

7570 W. 21st St. N. Bldg. 1046, Suite C Wichita, KS 67205 316-721-9005
1-800-658-1749 Fax 316-721-9044 kafp@kafponline.org
http://www.kafponline.org

Feb. 18, 2005

Linda Kenney, MPH, Director
Bureau for Children, Youth & Families
Kansas Department of Health & Environment
1000 SW Jackson, Suite 220, Topeka, KS 66612-1274

Dear Ms. Kenney,

Thank you for the opportunity to review the DRAFT MCH 2010 Kansas Maternal and Child Health 5-Year Needs Assessment. You have identified a number of important areas of concern that we share. Our members are the 820+ practicing family physicians in the state. Family physicians are the specialists who take care of more moms and kids than any other health care providers in the state. We applaud you for identifying and isolating many of the health care needs for this important group. We applaud you for selecting the priority needs. We are especially concerned about the priority of unmet access-to-care needs. The concept of the medical home is a key in which our members are heavily involved. We would be happy to work with you to further efforts to see that everyone

In addition to that focus, we note the intent to coordinate among and between various branches of KDHE. In that light, we urge you to further coordinate with KDHE's Tobacco Use and Prevention Program and focus on preventing tobacco use, the number one preventable cause of death in Kansas. We urge you to further coordinate with the KDHE's Immunization Program to see that our immunization rates rise in the state. A coordinated approach to these 2 issues alone will address many of the health care needs our members see everyday in their practice of medicine.

We also note that your notes on Structural Resources regarding data are of interest to us as well. We have concerns about the aging physician workforce and have been working to identify data sources. While it appears to exist and we hope to eventually gain access to it, we are certain that your statement about improving communication with data resources is very important.

Finally, we would volunteer to be involved in the group analyzing the KDHE organizational capacity development.

Thanks again for the opportunity to comment.

Sincerely,

Carolyn Gaughan, CAE
Executive Director

The mission of the Kansas Academy of Family Physicians is to promote access to and excellence in health care for all Kansans through education and advocacy for family physicians and their patients.

Public Comment #4

Kansas SAFE KIDS

1000 SW Jackson Street
Suite 230
Topeka, KS 66612-1274
(785) 296-1223
(785) 296-8645 (FAX)
jstegelm@kdhe.state.ks.us

March 9, 2005

Linda Kenney, Director
Bureau for Children, Youth & Families
Kansas Department of Health & Environment
1000 SW Jackson, Suite 220
Topeka, KS 66612-1274

Dear Ms. Kenney,

Thank you for the opportunity for Kansas SAFE KIDS to review and comment on the draft MCH 5-year needs assessment. We are pleased that you have implemented a comprehensive process for identifying and prioritizing the needs of Kansas children. We are particularly pleased that the assessment is data driven, and that prevention of unintentional injuries in Kansas children has been identified as a priority need for the children and adolescents population group. As you know, unintentional injuries are the leading cause of death for Kansas children. Our Coalition is also very interested in the area of cost information development as identified in your assessment as a need in our state.

We are also supportive of your emphasis on coordination of efforts. Members of our Coalition are interested in working with MCH programs to appropriately integrate proven unintentional injury prevention interventions and to assist as needed with your program planning needs.

Please let me know if we can be of assistance in your efforts to keep our children safe and healthy.

Sincerely,

Elena Nuss

Elena Nuss, Chairperson
Kansas SAFE KIDS Coalition

Public Comment #5

The University of Kansas Medical Center

School of Medicine
Developmental Disabilities Center

(913) 588-5900

March 25, 2005

Linda Kenney, MPH, Director
Bureau for Children, Youth & Families
Kansas Department of Health & Environment
1000 SW Jackson, Suite 220
Topeka, KS
66612-1274

Dear Ms. Kenney,

Thank you for giving us the opportunity to review the DRAFT MCH 2010 Kansas Maternal and Child Health 5-Year Needs Assessment document. We applaud particularly the emphasis on making certain that the children of Kansas have a medical home.

Developmental surveillance and screening is one very important activity that should take place in the medical home. Since our last MCH 2010 planning meeting, the CDC has initiated an awareness campaign to educate parents about childhood development, including early warning signs of autism and other developmental disorders. The CDC notes the necessity of "preparing the health community to deal with the increased questions and requests for information from parents".

The CDC also notes that "developmental screening can be done by various professionals in healthcare, community, or school settings". Given some of the barriers to optimal developmental screening in primary care practice, we would also support KDHE in efforts to expand routine developmental screening in Kansas beyond the physician's office. In Kansas, there are approximately 50,000 infants and toddlers in either center or home-based group child care, and another 22,000 children in child care provided by friends and family. Although the child care setting has not been a traditional target for developmental screening – child care providers have intimate knowledge of the children they care for, and the child care setting might be an ideal setting within which to target developmental screening efforts.

In summary - given increasing evidence that early intervention optimizes developmental outcomes for children with developmental delays and with autism, we would urge KDHE to expand opportunities for children to get state of the art developmental and autism screening in a variety of settings. We will also need to help prepare the health community of Kansas to make decisions for children who fail screening. KDHE should promote evidence-based screening practices for both developmental delay and autism. Many clinicians do not do screening, and even those following KBH guidelines for developmental screening will find that the suggested screening tests include tools that are no longer considered adequate (e.g. the Denver Developmental Screening Test – II), and that they do not include screening tests for autism. Furthermore,

there are now practice guidelines for medical evaluation of developmental delay and autism that need to be promoted in primary care.

We would be happy to work with KDHE to improve physician capacity for developmental screening and to promote physician-early intervention communication. We would also be happy to work with KDHE to support developmental screening in child care settings.

Sincerely,

Kathryn Ellerbeck, M.D.
Neurodevelopmental Pediatrician
Fellowship Director
Developmental Disabilities Center
University of Kansas Medical Center

R. Matthew Reese, Ph.D.
Licensed Psychologist
Training Director
Developmental Disabilities Center
University of Kansas Medical Center

Chet Johnson, M.D., F.A.A.P.
Neurodevelopmental Pediatrician
Professor of Pediatrics and Center Director
Developmental Disabilities Center
University of Kansas Medical Center

Georgina Peacock, M.D., F.A.A.P.
Developmental Behavioral Fellow
Developmental Disabilities Center
University of Kansas Medical Center

Jessica Foster, MD
Developmental Behavioral Fellow
Developmental Disabilities Center
University of Kansas Medical Center

Public Comment #6

March of Dimes
Saving babies, together

Greater Kansas Chapter
4050 Pennsylvania, Suite 141
Kansas City, Missouri 64111
816-561-0175

May 3, 2005

Linda Kenney, MPH, Director
Bureau for Children, Youth and Families
Kansas Department of Health and Environment
1000 SW Jackson, Suite 220
Topeka, KS 66612-1274

Dear Linda:

On behalf of the March of Dimes Greater Kansas Chapter, I thank you for the opportunity to participate as a panelist in the Kansas Maternal and Child Health 5-Year Needs Assessment process. I congratulate you on designing a process that effectively incorporates input from a large group of stakeholders representing diverse interests within maternal and child health. As you begin to design specific strategies to address the identified priorities, I would like to encourage you to include state performance measures in two specific areas:

1. ***Increased access to smoking prevention and cessation programs for pregnant women and women of childbearing age.*** *(Pregnant Women and Infants Subcommittee, Priority #2: Reduce premature births and low birthweight)*

   The March of Dimes is currently in the third year of a national research, awareness, and education campaign focused on premature birth. Originally designed as a five-year campaign, this initiative has recently been extended through 2010.

   Of course, premature birth is a complex problem with numerous contributing factors, many of which remain unknown at this time. However, smoking during pregnancy is a clearly defined risk factor that has a direct impact on pregnancy outcomes, and that can be modified during the course of pregnancy. In a 2001 report on women and smoking, the U.S. Surgeon General concluded that approximately 20% of the incidence of low birthweight in the U.S. can be attributed to smoking. The good news is that women who stop smoking during pregnancy can significantly reduce their risk of delivering a premature and/or a low birthweight baby.

   According to the Perinatal Casualty Study, approximately 12% of Kansas women smoke during pregnancy. The Surgeon General concludes that women who smoke are more likely than non-smokers to give birth to their babies prematurely. Pregnant women who smoke are also at higher risk of having a low birthweight baby - even if the baby is not born too early. Infants of women who smoke during pregnancy are 20-30% more likely to die before birth or within the first month of life. And, the risk of SIDS (Sudden Infant Death Syndrome) triples for babies whose mothers smoke during and after pregnancy.

   The March of Dimes endorses the 5 A's model, developed by the Smokefree Families Coalition, because it has the most consistent data to support its efficacy. Its widespread endorsement by the

American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP) and the Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) allows for a uniform approach to smoking cessation among various healthcare professional groups. Continued and expanded collaboration between existing smoking cessation efforts in BCYF programs and the KDHE Office of Health Promotion will strengthen services in public clinics and private practices throughout the state.

2. ***Increased capacity to screen, follow up, and treat infants and children with certain metabolic disorders.***

The March of Dimes supports comprehensive newborn screening for all babies in this country, regardless of their place of birth. Our policy is to support screening for specific conditions when there is a documented benefit to the child and there is a reliable test that enables early detection from newborn blood spots or other means. Based on the results of a study commissioned by the Maternal and Child Health Bureau in the fall of 2004, the March of Dimes expanded its recommended panel of core screening tests to at least 29 tests that meet these criteria. As you know, the Kansas newborn screening program currently offers four of these tests, while 30 other states offer at least 10 tests.

While these conditions are rare, collectively these 29 disorders could affect as many as 1 in 1,500 Kansas babies, according to the National Newborn Screening and Genetics Resource Center. Without early detection, these children can suffer a variety of debilitating symptoms, mental retardation, or even death. The medical care of these children may become very fragmented, as they go from physician to physician searching for a diagnosis of their symptoms.

The expansion of newborn screening and follow-up services in Kansas will require a collaborative effort among several agencies and organizations. We look forward to continuing our joint efforts in this area.

Again, thank you for the opportunity to provide input into the needs assessment process. If I can be of further assistance, please do not hesitate to call on me.

Sincerely,

Norm Hess

Norm Hess, MSA
Director of Program Services and Public Affairs

Public Comment #7

Dear Linda:

….You may recall that I am working on a small project for [the HRSA Maternal and Child Health Bureau] to write up state practices for obtaining public input on MCH block grant applications. I am doing this primarily by reviewing the '05 application sections on public input on line, as well as state health department websites to see what may be up about the MCH block grant. The results of this small study are intended as a resource for states as they plan public input activities for this spring and summer and for future years.

After reviewing all state health agency websites, it appears that at this point in time at least, only a handful are using their websites to actively solicit input into the MCH needs assessment, priorities or plans. Kansas is one of those states, and I wanted to ask you if you would be willing to share a little more information about what these mechanisms are yielding and any thoughts you may have about the value of these activities, especially vis-à-vis effort and cost....

Sincerely,

Catherine A. Hess
Health Policy Consultant
Washington, DC

MCH2010

Enhancing the health of Kansas women and children through partnerships with families and communities.

Appendix A.1

June 25, 2004 Meeting Assignment

Please review the attached indicator worksheet and fill in what you believe to be the ***five most important*** and ***five least important indicators***. As you are determining your top five indicators, consider:

1. Which indicators best ***communicate*** to stakeholders, providers, and/or consumers how well (or how poorly) the maternal and child health population in Kansas is doing?

2. Which indicators do the best job of ***measuring how well Kansas is meeting the goal*** of the maternal and child health program, particularly for your population group?

   Note: The overall goal is "enhancing the health of Kansas women and children through partnership with families and communities." The three MCH population groups are (1) pregnant women and infants, (2) children and adolescents, and (3) children with special health care needs.)

3. Which indicators are based on ***available and credible data***?

Five Most Important Indicators	**Five Least Important Indicators**
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____
5._____	5._____

Appendix A.2

MCH 2010 Needs Assessment

Tool #1: Data Indicator Selection

Part A (5-10 minutes). Review the following:

1. Who is your target population?

   All pregnant women and infants in Kansas.

   Maternal and Child Health Title V Definitions

   Infants: Child under one year of age.

   Pregnant women: A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus. However, many states also include the preconceptual health of a woman in her reproductive years (e.g., 15-44 years).

2. What is Kansas' goal for your target population?

   To enhance the health of Kansas women and infants in partnership with families and communities.

Part B (1 hour, 5 minutes). What data would be helpful to your group for determining the Kansas priority needs for your population group?

Please refer to your Indicator List for possible data indicators. Select candidate indicators from the list and, for each criterion, rate each indicator High, Medium, or Low. You may request data not currently listed, but please consult with your group's Data Representative and others in the group regarding availability. Only available indicators should be considered. Your group will be using the indicators you select today to help determine the priority needs for your target population on August 16th. The indicators you select also become candidates for performance measures to track the priority needs in Kansas over time.

Here are the criteria to help select your data indicators:

- **Communication Power**: Is this measure communicated easily? That is, would those who pay attention to Maternal Child Health in Kansas for your population group (e.g., state staff, legislators, funding sources, clinicians, clients, etc.) understand what this measure means?

- **Proxy Power**: Does this indicator measure something of central importance for you goal? Does this indicator measure the most important outcomes and efforts related to your population group?

- **Data Power**: Is the data both available and credible? Is quality data available on a consistent and timely basis?

Indicator Code / Indicator	Communication Power	Proxy Power	Data Power	Use this indicator for priority selection?

MCH 2010 Needs Assessment

Tool #1: Data Indicator Selection

Part A (5-10 minutes). Review the following:

1. Who is your target population?

   All children and adolescents in Kansas.

   Maternal and Child Health Title V Definition

   Child: A child from 1st birthday through the 21st year.

2. What is Kansas' goal for your target population?

   To enhance the health of Kansas children and adolescents in partnership with families and communities.

Part B (1 hour, 5 minutes). What data would be helpful to your group for determining the Kansas priority needs for your population group?

Please refer to your Indicator List for possible data indicators. Select candidate indicators from the list and, for each criterion, rate each indicator High, Medium, or Low. You may request data not currently listed, but please consult with your group's Data Representative and others in the group regarding availability. Only available indicators should be considered. Your group will be using the indicators you select today to help determine the priority needs for your target population on August 16th. The indicators you select also become candidates for performance measures to track the priority needs in Kansas over time.

Here are the criteria to help select your data indicators:

- **Communication Power**: Is this measure communicated easily? That is, would those who pay attention to Maternal Child Health in Kansas for your population group (e.g., state staff, legislators, funding sources, clinicians, clients, etc.) understand what this measure means?

- **Proxy Power**: Does this indicator measure something of central importance for you goal? Does this indicator measure the most important outcomes and efforts related to your population group?

- **Data Power**: Is the data both available and credible? Is quality data available on a consistent and timely basis?

Indicator Code / Indicator	Communication Power	Proxy Power	Data Power	Use this indicator for priority selection?

MCH 2010 Needs Assessment

Tool #1: Data Indicator Selection

Part A (5-10 minutes). Review the following:

1. Who is your target population?

   All children with special health care needs in Kansas.

   Definition

   Children with Special Health Care Needs: Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

2. What is Kansas' goal for your target population?

   To enhance the health of Kansas children with special health care needs in partnership with families and communities.

Part B (1 hour, 5 minutes). What data would be helpful to your group for determining the Kansas priority needs for your population group?

Please refer to your Indicator List for possible data indicators. Select candidate indicators from the list and, for each criterion, rate each indicator High, Medium, or Low. You may request data not currently listed, but please consult with your group's Data Representative and others in the group regarding availability. Only available indicators should be considered. Your group will be using the indicators you select today to help determine the priority needs for your target population on August 16th. The indicators you select also become candidates for performance measures to track the priority needs in Kansas over time.

Here are the criteria to help select your data indicators:

- **Communication Power**: Is this measure communicated easily? That is, would those who pay attention to Maternal Child Health in Kansas for your population group (e.g., state staff, legislators, funding sources, clinicians, clients, etc.) understand what this measure means?

- **Proxy Power**: Does this indicator measure something of central importance for you goal? Does this indicator measure the most important outcomes and efforts related to your population group?

- **Data Power**: Is the data both available and credible? Is quality data available on a consistent and timely basis?

Indicator Code / Indicator	Communication Power	Proxy Power	Data Power	Use this indicator for priority selection?

Appendix A.3

MCH 2010 Needs Assessment

Tool #2: Additional Data Needed

(1 hour) The desired data, if available, will be presented to you at the August 16th meeting. You will use this information to help determine Kansas' priority needs.

Instructions:

Please identify additional data needs for individual indicators on Tool #2. Examples include

Trend data

- Kansas
- National
- Other states with similar demographics (e.g., Iowa, Nebraska)

Demographic or population data

- Race/Ethnicity
- Age Group
- Gender

Geographic Data

- County
- City
- Population density (e.g., urban, rural)
- Region (define the regions per your data request)

Socioeconomic Data

- Education (e.g. mother's education level)

Qualitative Data (e.g., surveys, focus groups, key informant interviews)

Indicator Code / Indicator	Additional Data Needs		
	Contact Information - Name:	Email:	Phone:
	Contact Information - Name:	Email:	Phone:
	Contact Information - Name:	Email:	Phone:
	Contact Information - Name:	Email:	Phone:
	Contact Information - Name:	Email:	Phone:

Appendix B.1 Pregnant Women and Infant Indicators

Pregnant Women Indicators

			Kansas		United States					
Indicator Source	**Code**		**KS Number**	**KS Statistic**	**US Statistic**	**Healthy People 2010 Goal_Obj Code**	**Kansas Data Source**	**National Data Source**	**County Level Data**	**Comments**
Demographic Data										
KIC		Percent of population that are females		50.5% (2002)			KIC, 6/04		Yes	resident data
KIC		Percent of population that are females (15-44)		21.1% (2002)						
KIC		Live birth rate per 1,000 population (live births/total population)		14.5 (2002)	13.9 (2002)		CHES	NVSS,52(2)	Yes	resident data
Teenagers										
NPM_8, Miller, 1989	Preg1	The rate of birth (per 1,000) for teenagers (females) aged 15 through 17 years.	1,261 (2002)	21.2 (2002)	23.2 (2002)		CHES	NVSS,52(10)	Yes	resident data
	Preg2	Pregnancy rate per 1,000 adolescents (females) ages 15-17	1,684 (2002)	28.3 (2002)			CHES, Annual Report, T19, Teenage Pregnancy Report		Yes	resident data, pregnancy numbers include live births, fetal deaths, and abortions
	Preg3	Pregnancy rate per 1,000 adolescents (females) ages 15-19	5,500 (2002)	60.7(1999) 54.7(2002)	86.7 (1999)		CHES, Annual Report, T19, Teenage Pregnancy Report	NVSS,52(10)	Yes	resident data, pregnancy numbers include live births, fetal deaths, and abortions
Socioeconomic Indicator										
JSNA	Preg4	Percent of live births to women with less than 12 years of education	7,306 (2002)	18.6% (2002)	21.5% (2002)		CHES, Perinatal Casualty Study	NVSS,52(10)	Yes	resident data, % where ed. level stated
Health Status/Health Risk Indicators										
PRAMS, HP2010	Preg5	Prevalence of unintended pregnancy among women having a live birth		42.4% (1998)		30% (9.1)	BRFSS		No	Question: Thinking back to just before you got pregnant, how did you feel about becoming pregnant? (among women currently pregnant)
PRAMS	Preg6	Prevalence of drinking alcohol in the 3 months before conception		17.7%(2001 CY) 18.9 %(2003 FFY)	10.5% (2000 CY)		WIC, Table 10, PNSS	PNSS	Yes	
PRAMS	Preg7	Prevalence of drinking alcohol during the last 3 months of pregnancy		0.6% (2001CY) 0.3% (2003, FFY)	0.8% (2000 CY)		WIC, Table 10, PNSS	PNSS	Yes	
HP2010	Preg8	Percent of live births where the mother reported smoking during pregnancy	4,780 (2002)	12% (2002)	11.4% (2002)	1% (16-17c)	CHES, Perinatal Casualty Study	NVSS,52(10)	Yes	Birth certificate data
JSNA	Preg9	Percent linguistically isolated (language spoken at home is other than English)	184,530 (2002)	7.6% (2002)			U. S. Census, Am. Comm. Survey		No	In pop 5 years and over
Health System Indicators - Prenatal Care										
NPM_18, HP2010	Preg10	Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.		86.6% (2002)	82.1% (2002)	90% (16.6a)		NVSS,52(10)		
HP2010	Preg11	Increase the proportion of pregnant women who receive early and adequate prenatal care (APNCU).		79.4% (2002)	74.6% (2002)	90% (16.6b)	Pregnancy Research Summary		Yes	Resident Data, Percent of live births
Health System Indicators - Postpartum										
NPM_11	Preg12	Percentage of mothers who breast-fed their infants at hospital discharge.		72.2% (2002)	70.1%(2002)	75% (16-19a)	Mother's Survey, Ross Products	Mother's Survey, Ross Products	Not with this data source	
Mortality										
Peoples -Sheps, 1998	Preg13	Maternal mortality ratio (No. of deaths due to pregnancy or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy but not accidental or incidental cause/No. of live births	3 (2002)			3.3/100,000 live births			No	ICD-10 coding (O00-O99)

Infant Indicators

Indicator Source	Code		Kansas: Number, if appropriate	Kansas: KS Statistic	United States: US Statistic	Healthy People 2010 Goal/Obj.	Kansas Data Source	National Data Source	County Level Data	Comments
Demographics										
CHES		Kansas Live Residence Births	39,338 (2002)							Resident data
CHES		White	34,740							
CHES		Black or African American	2,872							
CHES		American Indian or Native Alaskan	443							
CHES		Asian or Native Hawaiian or Other PI	1,163							
CHES		Other and Unknown	120			C				
CHES		Hispanic	5,006							
CHES		Non-Hispanic	32,081							
CHES		Ethnicity Unknown	2,251							
Mortality Indicators										
NOM_01, HP2010	Inf1	Infant mortality rate per 1,000 live births	282 (2002)	7.2 (2002)	7 (2002)	4.5 (16.1c)	CHES,Annual Report	NVSS,52(13)	Yes	Resident data
PPOR	Inf2	Fetal deaths at 24 or more weeks of gestation per 1,000 live births					CHES		Yes	Resident data
HP2010, NOM_5	Inf3	The perinatal mortality rate per 1,000 live births	234 (2002)	5.9 (2002)		4.5 (16.1b)	CHES		Yes	Resident data
NOM_3	Inf4	Neonatal Deaths (<28 days) per 1,000 live births	192 (2002)	4.9 (2002)	4.7 (2002)	2.9 (16.1d)	CHES,Annual Report		Yes	Resident data
NOM_4	Inf5	Postneonatal mortality (28 days-<1 year) per 1,000 live births	90 (2002)	2.8 (2001) 2.3	2.3(2001)	1.2 (16.1e)	CHES	NVSS,52(2)	Yes	Resident data
Peoples-Sheps,1998	Inf6	Postneonatal mortality of term infants weighing < 2500 g at birth							Yes	Resident data
HP2010	Inf7	All infant deaths from all birth defects per 1,000 live births	63 (2002)	1.6 (2002)	1.4(2002)	1.1 (16.1f)	CHES, Annual Report	NVSS,52(13)	Yes	Resident data
HP2010	Inf8	Infant death rate from sudden infant death syndrome per 1,000 live births.	46 (2002)	1.2 (2002)	0.51(2002)	0.25 (16.1h)	CHES, Annual Report	NVSS,52(13)	Yes	Resident data
NOM_2	Inf9	The ratio of the black infant mortality rate to the white infant mortality rate.		2.5 (2002)	2.5(2002)		CHES, Annual Report	NVSS,52(13)	Yes	Resident data
Health Status										
NPM_01	Inf10	The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinpathies) who receive appropriate follow up as defined by their State.	24 (2002)	100% (2002)			Newborn Screening Program		Yes	Occurance data
NPM_12	Inf11	Percentage of newborns who have been screened for hearing before hospital discharge.		90.4% (2003)					Yes	Occurance data
Health Risk Indicators										
HP2010	Inf12	Rate per 1,000 live births with congenital anomalies	519 (2002)	13.2 (2002)			CHES, Perinatal Casualty Report		Yes	Resident data
Low Birth Weight Infants										
Miller, 1989, HSI_01A	Inf13	Percent of live births weighing less than 2500 g. (5.5 lb).	2,758 (2002)	7.0% (2002)	6.1% (2002)	5.0% (16-10a)	CHES	NVSR,52(10)	Yes	Resident data
HSI_01B	Inf14	Percent low birth weight (below 2,500 grams) among all live singleton births	2,018 (2002)	5.3% (2002)			CHES		Yes	Resident data
NPM_15, HSI_02A	Inf15	The percent of very low birth weight infants among all live births.	515 (2002)	1.3% (2002)	1.1% (2002)	0.9% (16-10b)	CHES	NVSR,52(10)	Yes	Resident data
HSI_02B	Inf16	Percent low birth weight (below 1,500 grams) singleton births	358 (2002)	0.9% (2002)			CHES		Yes	Resident data
Health System Indicator										
NPM_17	Inf17	Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.		82.6% (2002)		90% (16-8)			Yes	Resident data

Abbreviations:

CHES - Centers for Health & Environmental Statistics, KDHE
HP2010 - Healthy People 2010

HSI - Health status indicator from Maternal Child Health (MCH) Block Grant
HSCI - Health Systems Capacity Indicator from Maternal Child Health Block Grant
JSNA - MCH State Needs Assessment

KIC - Kansas Information for Communities
NOM - National Outcome Measure from Maternal Chld Health Block Grant

NPM - National Performance Measure from Maternal Child Health (MCH) Block Grant
PRAMS - Pregnancy Risk Assessment Monitoring System

Appendix B.2 Child and Adolescent Indicators

			Kansas		United States					
Indicator Source	**Code**	**Children and Adolescents Indicators**	**KS Number if Appropriate**	**KS Statistic**	**US Statistic**	**Healthy People 2010 Goal**	**KS Data Source**	**US Data Source**	**County Level Data**	**Comments**
Demographics										
		Children ages 0-24	988,028 (2002)				U.S. Census			
		White	868,740							
		Black or African American	81,781							
		American Indian or Native Alaskan	13,779							
		Asian or Native Hawaiian or Other PI	23,728							
		Hispanic	105,498							
		Non-Hispanic	882,530							
Socioecomic Factors										
Grandparents										
		Number of grandparents with their own grandchildren under 18 years in households	34,337 (2002)				U.S. Census, Am. Comm. Survey	U.S. Census, Am. Comm. Survey	No, 2002, Yes, 2000	
		Percent of grandparents responsible for their grandchildren under 18 years of age who are in poverty		16% (2002)	18.2% (2002)		U.S. Census, Am. Comm. Survey	U.S. Census, Am. Comm. Survey	No, 2002, Yes, 2000	
Other Socioecomic Factors										
		Percent of individuals with related children under 5 years below poverty in the past 12 months		21.2%(2002)				US Census		
		Percent of individuals with related children 5-17 below poverty in the past 12 months		13.4%(2002)				US Census		
		Percent of children under 19 years of age at or below 200% of the Federal Poverty level without health insurance (three-year averages for 2000, 2001, and 2002).	39,000	5.50%	7.50%		US Census			
Health Status/Health Risk Indicators										
NPM_13	CA1	Percent of children without health insurance.	57,000 (2002)	8.1% (2002)	11.6% (2002)		US Census	US Census	No	Children/adolescents aged < 18
Peoples-Sheps, 1998	CA2	The percent of children who are overweight.		14.3%(2002)	13.5% (2002)	5% (age 6-19)	PedNS Summary, Table 2c	PedNSS 2002 Report, CDC	Yes	Children ages 2-5
Peoples-Sheps, 1998	CA3	Prevalence of anemia in children		10.0% (2002)	13.1% (2002)	5% (age 1-2) 1% (age 3-4)	PedNSS 2002 Report, CDC	PedNSS 2002 Report, CDC	Yes	Children aged < 5
NPM_7	CA4	Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.		66.8% (2002)	74.8% (2002)	90%	National Immunization Survey	National Immunization Survey	No	
NPM_9	CA5	Percent of third grade children who have received protective sealants on at least one permanent molar tooth.	196,208 (2002)	45.1%(2002)			BRFSS		No	Data in BRFSS not by grade. BRFSS data, 2002, indicates that 45.1 % of children 7-17 had dental sealants placed on his/her teeth

Appendix B.2 Child and Adolescent Indicators

			Kansas		United States					
Indicator Source	**Code**	**Children and Adolescents Indicators**	**KS Number if Appropriate**	**KS Statistic**	**US Statistic**	**Healthy People 2010 Goal**	**KS Data Source**	**US Data Source**	**County Level Data**	**Comments**
HSCI_7	CA6	Percent of children who have received dental care.	13,526 (2002)	37.5%(2002)			SRS		Yes	Percent of Kan be Healthy eligible children aged 6-9 who have received at least one dental screen
Miller, 89	CA7	The rate/1,000 of children under 18 years of age who are victims of child abuse and neglect.		10.2 (2001)	12.4 (2001)	10.3	Child Maltreatment 2001, NCANDS		No	
Miller, 89	CA8	The number of children within a defined population found to have blood lead levels of >=10 micrograms/deciliter	262(2001)				Childhood Lead Poisoning Prevention Program		Yes	Children 6 years and under
HP2010	CA9	Reduce use of cigarettes in past month by students in grades 9 through 12 to 16%.		26.1%(2000) 21.1%(2002)	28.0%(2000)	16%	Tobacco Use Prevention program	TIPS, CDC	No	
Motor Vehicle Crashes										
NPM_10	CA10	The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children	29 (2002)	6.1(2001) 5.1(2002)	4.1(2001)		CHES	WISQARS	Yes	Unintentional Injury
HS_03C	CA11	The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.	164 (2002)	39.6 (2002)					Yes	
HS_04B	CA12	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.	169 (2002)	28.7 (2002)			KDOT		Yes	Based on "disabling" injuries to motor vehicle occupants, pedestrians, and pedacyclists resulting from motor vehicle crashes occurring in-state.
HS_04C	CA13	The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 15 through 24 years.	744 (2002)	185.9 (2002)			KDOT		Yes	Based on "disabling" injuries to motor vehicle occupants, pedestrians, and pedacyclists resulting from motor vehicle crashes occurring in-state.
	CA14	Percent of children/adolescents correctly restrained in a motor vehicle crash by age groups 0-3, 4-8, 9-19.	age 0-3 3,856(2002)	age 0-3 71.7%(2002)			KDOT		Yes	The Child Passenger Safety Act (KSA 8-1344), which requires all children under the age of four to be in a federally-approved child safety seat.
Other Mortality										
NOM_6	CA15	The child death rate per 100,000 children aged 1 through 14.	130 (2002)	23.6 (2001) 24.3 (2002)	21.6 (2001)		CHES	WISQARS	Yes	
HS_03A	CA16	The death rate per 100,000 due to unintential injuries among children aged 14 years and younger.	62 (2002)	10.8 (2002)			CHES		Yes	
Hositalization data										
HSC_01	CA17	The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than 5 years of age	615 (2001)	27.1 (1999) 32.6 (2001)	55.4 (1999)	25.0	Hospital Discharge Data	NHDS	Yes	
HS_04A	CA18	The rate per 10,000 of all nonfatal injuries among children aged 14 years and younger		17.1 (2001)			Hospital Discharge Data		Yes	
	CA19	Repiratory inpatient hospitalizations per 10,000 children age 1-4		203.9 (2001)			Hospital Discharge Data		Yes	

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			Kansas		United States					
Indicator Source	**Code**	**Children and Adolescents Indicators**	**KS Number if Appropriate**	**KS Statistic**	**US Statistic**	**Healthy People 2010 Goal**	**KS Data Source**	**US Data Source**	**County Level Data**	**Comments**
Mental Health										
Peoples-Sheps,1998	CA20	The rate of adolescents ages 15-19 hospitalized for self-harm (ICD-9 Codes: E950 -E9599) per 10,000 population	208 (2000)	9.9 (2000)			Hospital Discharge Data		Yes	Female to Male ratio, 3:1
NPM_16	CA21	The rate (per 100,000) of suicide deaths among youths aged 15 through 19.	18 (2002)	13.3(2001) 8.7(2002))	8.0(2001)		CHES	WISQARS	Yes	
Sexual Behavior										
HSI_05A	CA22	The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.	2,256	22.4(2002)			STD Section, KDHE.		Yes	
NPM_8, Miller, 1989	Preg1	The rate of birth (per 1,000) for teenagers (females) aged 15 through 17 years.	1,261 (2002)	21.2 (2002)	23.2 (2002)		CHES	NVSS,52(10)	Yes	resident data
	Preg2	Pregnancy rate per 1,000 adolescents (females) ages 15-17	1,684 (2002)	28.3 (2002)			CHES, Teenage Pregnancy Report		Yes	resident data, pregnancy numbers include live births, fetal deaths, and abortions
	Preg3	Pregnancy rate per 1,000 adolescents (females) ages 15-19	5,500 (2002)	60.7(1999) 54.7(2002)	86.7 (1999)		CHES, Teenage Pregnancy Report	NVSS,52(10)	Yes	resident data, pregnancy numbers include live births, fetal deaths, and abortions

Abbreviations:

CHES - Centers for Health & Environmental Statistics, KDHE
HP2010 - Healthy People 2010
HSI - Health status indicator from Maternal Child Health (MCH) Block Grant
HSCI - Health Systems Capacity Indicator from Maternal Child Health Block Grant
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PRAMS - Pregnancy Risk Assessment Monitoring System

Appendix B.3 Children with Special Health Care Needs (CSHCN) Indicators

			Kansas		US					
Indicator Source	**CODE**	**CSHCN HEALTH INDICATORS**	**KS Number**	**KS Statistic**	**Statistic**	**Healthy People 2010 Goal**	**Kansas Data Source**	**US Data Source**	**County Level Data**	**Comments**
CSHCN Survey, 2001		***State Profiles***					CSHCN Survey, 2001	CSHCN Survey, 2001		
		Demographic indicator								
	CSHCN1	% of children with special health care needs age 0 to 17: Households		23.2%	20.0%					
	CSHCN2	% of children with special health care needs age 0 to 17: Person		14.7%	12.8%					
		Age 0-5		8.4	7.8					
		Age 6-11		17.5	14.6					
		Age 12-17		17.7	15.8					
		Age 0-3		6.6	6.5					
		Age 4-7		13.2	11.4					
		Age 8-11		18.9	15.5					
		Age 12-14		17.6	16.2					
		Age 15-17		18.0	14.7					
		Female		12.6	10.5					
		Male		16.8	15.0					
		White (Non-Hispanic)		15.4	14.2					
		Black or African American (Non-Hispanic)		15.5	13.0					
		Multi-racial (Non-Hispanic)		18.8	15.1					
		Asian (Non-Hispanic)		N/A	4.4					
		Native American/Alaskan Native (Non-Hispanic)		N/A	16.6					
		Native Hawaiian/Pacific Islander (Non-Hispanic)		N/A	9.6					
		Hispanic		9.1	8.5					
		Household poverty status								
		0-99% FPL		17.3	13.6					
		100-199% FPL		12.9	13.6					
		200-399% FPL		15.4	12.8					
		400% FPL or greater		15.9	13.6					
		Child Health indicator (age 0-17)								
	CSHCN3	% of CSHCN whose health conditions consistently and often greatly affect their daily activities.		19.8	23.2					
	CSHCN4	% of CSHCN with 11 or more days of school absences due to illness.		10.3	15.8					
		Coverage indicator (age 0-17)								
	CSHCN5	% of CSHCN without insurance at some point during the past year.		9.1	11.6					
	CSHCN6	% of CSHCN currently uninsured.		4.4	5.2					
	CSHCN7	% of currently insured CSHCN with coverage that is not adequate.		31	33.8					
		Access to Care indicator (age 0-17)								
	CSHCN8	% of CSHCN with one or more unmet needs for specific health care services.		19.2	17.7					
	CSHCN9	% of CSHCN whose families needed but did not get all respite care, genetic counseling and/or mental health services.		34.1	23.1					
	CSHCN10	% of CSHCN needing specialty care who had problems getting a referral.		20.5	21.9					
	CSHCN11	% of CSHCN without a usual source of care (or who rely o the emergency room).		7.4	9.3					
	CSHCN12	% of CSHCN without a personal doctor or nurse.		5.9	11					
		Family-Centered Care indicator (age 0-17)								
	CSHCN13	% of CSHCN without family-centered care.		29.8	33.2					

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Indicator Source	**CODE**	**CSHCN HEALTH INDICATORS**	**KS Number**	**KS Statistic**	**Statistic**	**Healthy People 2010 Goal**	**Kansas Data Source**	**US Data Source**	**County Level Data**	**Comments**
		Impact on Family indicator (age 0-17)								
	CSHCN14	% of CSHCN whose families pay $1,000 or more in medical expenses per year.		12.5	11.2					
	CSHCN15	% of CSHCN whose families experienced financial problems due to child's health needs.		24.4	20.9					
	CSHCN16	% of CSHCN whose families spend 11 or more hours per week providing and/or coordinating health care for child.		12.3	13.5					
	CSHCN17	% of CSHCN whose health needs caused family members to cut back or stop working		27.8	29.8					
MCH BG & CSHCN Survey, 2001		***National Performance Measures***								
MCH BG NPM2	CSHCN18	Percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.		59.1%	57.5%				No	
		a. Doctors usually or always made the famil feel like a partner		83.8	84.3		CSHCN Survey, 2001	CSHCN Survey, 2001		
		b. Family was very satisfied with services received		61.7	60.1					
MCH BG NPM3	CSHCN19	Percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.		58.9	52.6				No	
		a. The child has a usual source of care		92.7	90.5					
		i. The child has a usual source for sick care		92.6	90.6					
		ii. The child has a usual source for preventive care		99.8	98.8					
		b. The child has a personal doctor or nurse		94.1	89.0					
		c. The child has no problems obtaining referrals when needed		79.5	78.1					
		d. Effective care coordination is received when needed		21.8	39.8					
		i. The child has professional care coordination when needed		73.2	81.9					
		ii. Doctors communicate well with each other (excellent/very good)		36.3	54.4					
		iii. Doctors communicate well with other programs (excellent/very good)		32.0	37.1					
		e. The child receives family-centered care		70.2	66.8					
		i. Doctors usually or always spend enough time		83.6	83.6					
		ii. Doctors usually or always listen carefully		88.2	88.1					
		iii. Doctors are usually or always sensitive to values and customs		90.0	87.0					
		iv. Doctors usually or always provide needed information		83.4	81.0					
		v. Doctors usually or always make the family feel like a partner		86.8	85.9					
MCH BG NPM4	CSHCN20	Percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.		63.9	59.6			CSHCN Survey, 2001	No	
		a. The child has public or private insurance at time of interview		95.6	94.8					
		b. The child has no gaps in coverage during the year prior to the interview.		90.9	88.4					
		c. Insurance usually or always meets the child's needs		87.6	85.5					
		d. Costs not covered by insurance are usually or always reasonable.		73.6	71.6					
		e. Insurance usually or always permits child to see needed providers		91.3	87.8					
MCH BG NPM5	CSHCN21	Percent of children with special health care needs age 0 to 18 whose families reprot the community-based service systems are organized so they can use them easily.		70.9	74.3			CSHCN Survey, 2001	No	
		a. Services are usually or always organized for easy use.		70.9	74.3					
MCH BG NPM6	CSHCN22	Percent of youth with special health care needs who received the services necessary to make transition to all aspects of adult life.		5.2*	5.8			CSHCN Survey, 2001	No	
		a. The child receives guidance and support in the transition to adulthood.		15.8	15.3					
		i. Doctors have talked about changing needs.		48.6	50					
		ii. The child has a plan for addressing changing needs.		59.7	59.3					
		iii. Doctors discussed shift to adult provider.		37.8	41.8					
		b. The child has received vocational or career training.		19.7	25.5					

Appendix B.3 Children with Special Health Care Needs (CSHCN) Indicators

			Kansas		US					
Indicator Source	**CODE**	**CSHCN HEALTH INDICATORS**	**KS Number**	**KS Statistic**	**Statistic**	**Healthy People 2010 Goal**	**Kansas Data Source**	**US Data Source**	**County Level Data**	**Comments**
MCH BG HSCI7	CSHCN23	Percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.		33.2						
CSHCN Survey, 2001		***Additional Inidcators (age 0-17)***								
		% of all children qualified on prescription (RX) Medication screening criteria		11.8	9.5					
		% of all children qualified on service use/need screening criteria		6.7	5.8					
		% of all children qualified on functional limitations screening criteria		2.9	2.7					
		% of all children qualified on specialized therapies screening criteria		2.3	2.2					
		% of all children ualified on mental health screening criteria		4.0	3.7					
	CSHCN24	% of all CSHCN qualified on prescription (RX) Medication screening criteria		79.9	74.2					
	CSHCN25	% of all CSHCN qualified on service use/need screening criteria		45.8	45.6					
	CSHCN26	% of all CSHCN qualified on functional limitations screening criteria		19.6	21.3					
	CSHCN27	% of all CSHCN qualified on specialized therapies screening criteria		15.4	17.4					
	CSHCN28	% of all CSHCN qualified on mental health screening criteria		27.5	28.7					
		Among all children (age 0-17):								
		Specific types of special health needs:								
		CSHCN whose conditions result in functional limitations		2.9	2.7					
		CSHCN whose conditions are managed with prescription medicines		6.0	4.7					
		CSHCN whose conditions result in above routine use of medical, mental health or other services		1.9	2.3					
		CSHCN whose conditions require prescription medicine and abouve routine use of services		3.9	3.0					
		Among all CSHCN (age 0-17):								
	CSHCN29	Specific types of special health needs:								
		CSHCN whose conditions result in functional limitations		19.6	21.3					
		CSHCN whose conditions are managed with prescription medicines		40.6	36.7					
		CSHCN whose conditions result in above routine use of medical, mental health or other services		13.1	18.2					
		CSHCN whose conditions require prescription medicine and abouve routine use of services		26.7	23.7					
CSHCN Survey, 2001		***Additional Health Insurance Coverage***								
		Percent of (all) children under 18 years of age by type of health insurance coverage								
		a. Uninsured		**7.4**	**8.3**					
		b. Private		76.2	69.3					
		c. Public		11.8	16.8					
		d. Private and Public		4.1	5.1					
		e. Other comprehensive Insurance		0.5	0.5					
CSHCN Survey, 2001	CSHCN30	Percent of children under 18 years of age **with** special health care needs by type of health insurance coverage								
		a. Uninsured*		**4.4**	**5.2**					*P-values were less than .05 indicated that the difference between the uninsurance rates was statistically significant. The uninsurance rate for children without special health care needs was greater that the uninsurance rate for children with special health care needs.
		b. Private		70.5	64.7					
		c. Public		16.8	21.7					
		d. Private and Public		8	8.1					
		e. Other comprehensive Insurance		0.3	0.4					
CSHCN Survey, 2001		Percent of children under 18 years of age **without** special health care needs by type of health insurance coverage.								
		a. Uninsured*		**7.9**	**8.7**					

Appendix B.3 Children with Special Health Care Needs (CSHCN) Indicators

			Kansas		US					
Indicator Source	**CODE**	**CSHCN HEALTH INDICATORS**	**KS Number**	**KS Statistic**	**Statistic**	**Healthy People 2010 Goal**	**Kansas Data Source**	**US Data Source**	**County Level Data**	**Comments**
		b. Private		77.2	70					
		c. Public		10.9	16.1					
		d. Private and Public		3.5	4.7					
		e. Other comprehensive Insurance		0.5	0.5					
CSHCN Survey, 2001		Percent of children under 18 years old **without health insurance** and with income **below 200%** of the Federal Poverty level.		**4.9**	**5.6**					
CSHCN Survey, 2001		Percent of children under 18 years of age **without** health insurance coverage by selected demographic characteristics and by health status								
	CSHCN31	***Children with special health care needs***								
		Age in years								
		0-5			4.8					
		6-11			4.7					
		12-17			5.9					
		Sex								
		Female			5.4					
		Male			5.1					
		Race/Ethnicity								
		Hispanic			10.1					
		Black (non-Hispanic)			5.3					
		White (non-Hispanic and all others)			4.5					
		Language of interview								
		English			4.7					
		Spanish or other language			21					
		Household income								
		Up to $9,999			8.6					
		$10,000 - $19,999			10.2					
		$20,000 - $39,999			8.9					
		$40,000 - $59,999			4.9					
		$60,000 and over			2					
		Household poverty status								
		Up to 49% of Federal Poverty Level (FPL)			9.2					
		50% - 99% of FPL			9.8					
		100% - 149% of FPL			9.7					
		150% - 199% of FPL			7.8					
		200% of FPL and over			3					
		Maternal education								
		Eighth grade or less			18.3					
		Some high school			7.9					
		High school graduatge or G.E.D.			6					
		Some post-high school, but no college degree			4.6					
		Four-year college degree or higher			2.1					
		Children without special health care needs								
		Age in years								
		0-5			7.4					

Appendix B.3 Children with Special Health Care Needs (CSHCN) Indicators

			Kansas		US					
Indicator Source	**CODE**	**CSHCN HEALTH INDICATORS**	**KS Number**	**KS Statistic**	**Statistic**	**Healthy People 2010 Goal**	**Kansas Data Source**	**US Data Source**	**County Level Data**	**Comments**
		6-11			4.7					
		12-17			5.9					
		Sex								
		Female			8.7					
		Male			8.7					
		Race/Ethnicity								
		Hispanic			20					
		Black (non-Hispanic)			7.6					
		White (non-Hispanic and all others)			6					
		Language of interview								
		English			6.5					
		Spanish or other language			27.9					
		Household income								
		Up to $9,999			18.4					
		$10,000 - $19,999			18.9					
		$20,000 - $39,999			14.8					
		$40,000 - $59,999			7					
		$60,000 and over			2.6					
		Household poverty status								
		Up to 49% of Federal Poverty Level (FPL)			19.9					
		50% - 99% of FPL			19.8					
		100% - 149% of FPL			16.4					
		150% - 199% of FPL			11.9					
		200% of FPL and over			4					
		Maternal education								
		Eighth grade or less			29					
		Some high school			17.6					
		High school graduatge or G.E.D.			8.6					
		Some post-high school, but no college degree			5.7					
		Four-year college degree or higher			2.9					
		All Children								
		Age in years								
		0-5			7.2					
		6-11			8.4					
		12-17			9.2					
		Sex								
		Female			8.4					
		Male			8.2					
		Race/Ethnicity								
		Hispanic			19.2					
		Black (non-Hispanic)			7.3					
		White (non-Hispanic and all others)			5.8					
		Language of interview								

Appendix B.3 Children with Special Health Care Needs (CSHCN) Indicators

			Kansas		US					
Indicator Source	**CODE**	**CSHCN HEALTH INDICATORS**	**KS Number**	**KS Statistic**	**Statistic**	**Healthy People 2010 Goal**	**Kansas Data Source**	**US Data Source**	**County Level Data**	**Comments**
		English			6.3					
		Spanish or other language			27.5					
		Household income								
		Up to $9,999			17.0					
		$10,000 - $19,999			17.7					
		$20,000 - $39,999			14.0					
		$40,000 - $59,999			6.7					
		$60,000 and over			2.5					
		Household poverty status								
		Up to 49% of Federal Poverty Level (FPL)			18.5					
		50% - 99% of FPL			18.4					
		100% - 149% of FPL			15.5					
		150% - 199% of FPL			11.4					
		200% of FPL and over			3.8					
		Maternal education								
		Eighth grade or less			28.3					
		Some high school			16.3					
		High school graduatge or G.E.D.			8.3					
		Some post-high school, but no college degree			5.5					
		Four-year college degree or higher			2.8					
		Additional Health Status / Health Risk Indicators								
HP2010		**16-14. Reduction in Developmental Disabilities in Children**								
	CSHCN32	*16-14a. Mental retardation (Rate per 10,000)*			131 (1991-94 baseline)	124		Metropolitan Atlanta Developmental Disabilities Surveillance Program (MADDSP), CDC, NCEH.		*DNA=Data have not been analyzed. DNC=Data are not collected.*
		Race:								
		American Indian or Alaska Native			DNA					
		Asian or Pacific Islander			DNA					
		Black or African American			210					
		White			85					
		Ethnicity:								
		Hispanic or Latino			DNA					
		Non-Hispanic or Latino			DNA					
		Gender:								
		Female			107					
		Male			154					
		Family income level:								
		Poor			DNC					
		Near poor			DNC					
		Middle/high income			DNC					
	CSHCN33	*Cerebral Palsy (Rate per 10,000)*			32.2 (1991-94 baseline)	31.5				
		Race:								
		American Indian or Alaska Native			DNA					
		Asian or Pacific Islander			DNA					
		Black or African American			38.4					
		White			30.4					
		Ethnicity:								

Appendix B.3 Children with Special Health Care Needs (CSHCN) Indicators

			Kansas		US					
Indicator Source	**CODE**	**CSHCN HEALTH INDICATORS**	**KS Number**	**KS Statistic**	**Statistic**	**Healthy People 2010 Goal**	**Kansas Data Source**	**US Data Source**	**County Level Data**	**Comments**
		Hispanic or Latino			DNA					
		Non-Hispanic or Latino			DNA					
		Gender:								
		Female			30.8					
		Male			35.5					
		Family income level:								
		Poor			DNC					
		Near poor			DNC					
		Middle/high income			DNC					
		16-15. Reduce the occurrence of spina bifida and other neural tube defects (NTDs)						*National Birth Defects Prevention Network (NBDPN), CDC, NCEH.*		
	CSHCN34	*Spina Bifida or other NTDs (per 10,000 live births)*			6.0 (1991-94 baseline)	3.0				
		16-16. Increase the proportion of pregnancies begun with an optimum folic acid level.								*DSU: Data are statistically unreliable.*
	CSHCN35	*Consumption of at least 400 ug of folic acid each day from fortified foods or dietary supplements by nonpregnant women aged 15 to 44 years*			21% (1991-94 baseline)	80%		*Data Source: National Health and Nutritional Examination Survey (NHANES), CDC, NCHS.*		
		Race:								
		Black or African American			17%					
		White			22%					
		Ethnicity:								
		Hispanic or Latino			DSU					
		Non-Hispanic or Latino			22%					
		Education level:								
		Less than high school			12%					
		High school graduate			19%					
		At least some college			28%					
		Disability Status:								
		Persons with disabilities			20%					
		Persons without disabilities			23%					
	CSHCN36	*Median RBC folate level among non-pregnant women aged 15 to 44 years*			160 ng/ml (1991-94 baseline)	220 ng/mg				
		Race:								
		Black or African American			125					
		White			169					
		Ethnicity:								
		Hispanic or Latino			DSU					
		Non-Hispanic or Latino			159					
		Education level:								
		Less than high school			149					
		High school graduate			148					
		At least some college			179					
		Disability Status:								
		Persons with disabilities			169					
		Persons without disabilities			159					
	CSHCN37	Medical Home			n.a.	n.a.				
	CSHCN38	% Service Systems for CSHCN			15.7% (1997)	100				

Appendix B.3 Children with Special Health Care Needs (CSHCN) Indicators

			Kansas		US					
Indicator Source	**CODE**	**CSHCN HEALTH INDICATORS**	**KS Number**	**KS Statistic**	**Statistic**	**Healthy People 2010 Goal**	**Kansas Data Source**	**US Data Source**	**County Level Data**	**Comments**
JSNA	CSHCN39	Congenital anomalies (rate per 100,000 live births)		160.2 (2002)	140.7 (2002)					
JSNA	CSHCN40	Respiratory inpatient hospitalizations per 10,000 children aged 0 to 17								
JSNA	CSHCN41	Low birth weight births (Rate for 100,000 live births)		165.2 (2002)	114.4 (2002)					
JSNA	CSHCN42	APGAR scores								
		Additional Access / Resource Indicators								
JSNA	CSHCN43	Special education students to special education provider full time employee (FTE) ratio								
JSNA	CSHCN44	Estimated children with cleft lip/palate or hearing impairment per audiologist								
JSNA	CSHCN45	Estimated children with cleft lip/palate or hearing impairment per speech pathologist								
JSNA	CSHCN46	Estimated unmet need: Estimated percent of all Kansas CSHCN served by the CSHCN program								
JSNA	CSHCN47	Estimated unmet need: neural tube defects								
JSNA	CSHCN48	Percent of women (15-44) using folic acid								
JSNA	CSHCN49	Estimated unmet need: crebral palsy								
JSNA	CSHCN50	Estimated unmet need: cardiac conditions								
JSNA	CSHCN51	Estimated unmet need: cleft lip / cleft palate								
JSNA	CSHCN52	Percent of primary care physician FTEs enrolled as CSHCN providers								
JSNA	CSHCN53	Care coordination, primary care: Percent of CSHCN primary care physicians who regularly communicate with others on their patients care teams								
JSNA	CSHCN54	Care coordination, specialist: Percent of CSHCN specialist physicians who regularly communicate with others on their patients care teams								
JSNA	CSHCN55	Percent of CSHCN priamry care physicians who have patients who travel over 100 miles								
JSNA	CSHCN56	Percent of CSHCN dentists who have patients who travel over 100 miles								
JSNA	CSHCN57	Percent of CSHCN specialists who have patients who travel over 100 miles								

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Appendix C.1

MCH 2010 Needs Assessment

Tool #3: Identify Possible Priorities

1. Target Population:

   All women of childbearing age and infants in Kansas.

   Infants: Child under one year of age.

2. Goal for target population:

   To enhance the health of Kansas women and infants in partnership with families and communities.

3. What are some conclusions can we draw from the data presented?

4. Based on data findings and your expert opinion, list no more than 10 potential priorities on the following page for your population group. It may help to envision the results you expect for Kansas pregnant women and infants in 2010. For example, “All pregnant women will receive early and adequate prenatal care.”

Pregnant Women and Infants Potential Priorities

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)

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Appendix C.1

MCH 2010 Needs Assessment

Tool #3: Identify Possible Priorities

1. Target Population:

   All children and adolescents in Kansas.

   Maternal and Child Health Title V Definition

   Child: A child from 1st birthday through the 21st year.

2. Goal for target population:

   To enhance the health of Kansas children and adolescents in partnership with families and communities.

3. What are some conclusions can we draw from the data presented?

4. Based on data findings and your expert opinion, list no more than 10 potential priorities on the following page for your population group. It may help to envision the results you expect for Kansas children and adolescents in 2010. For example, "Teens will delay sexual activity until marriage."

Children and Adolescents Potential Priorities

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)

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Appendix C.1

MCH 2010 Needs Assessment

Tool #3: Identify Possible Priorities

1. Target Population:

   All children with special health care needs in Kansas.

   Definition

   Children with Special Health Care Needs. Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

2. Goal for target population:

   To enhance the health of Kansas children with special health care needs in partnership with families and communities.

3. What are some conclusions can we draw from the data presented?

4. Based on data findings and your expert opinion, list no more than 10 potential priorities on the following page for your population group. It may help to envision the results you expect for Kansas children with special health care needs in 2010. For example, “Children with special health care needs will have a medical home.”

CSHCN Potential Priorities

1)

2)

3)

4)

5)

6)

7)

8)

9)

10)

Appendix C.2

Tool #4: Q-Sort

MCH 2010 Needs Assessment

Selection of Priorities

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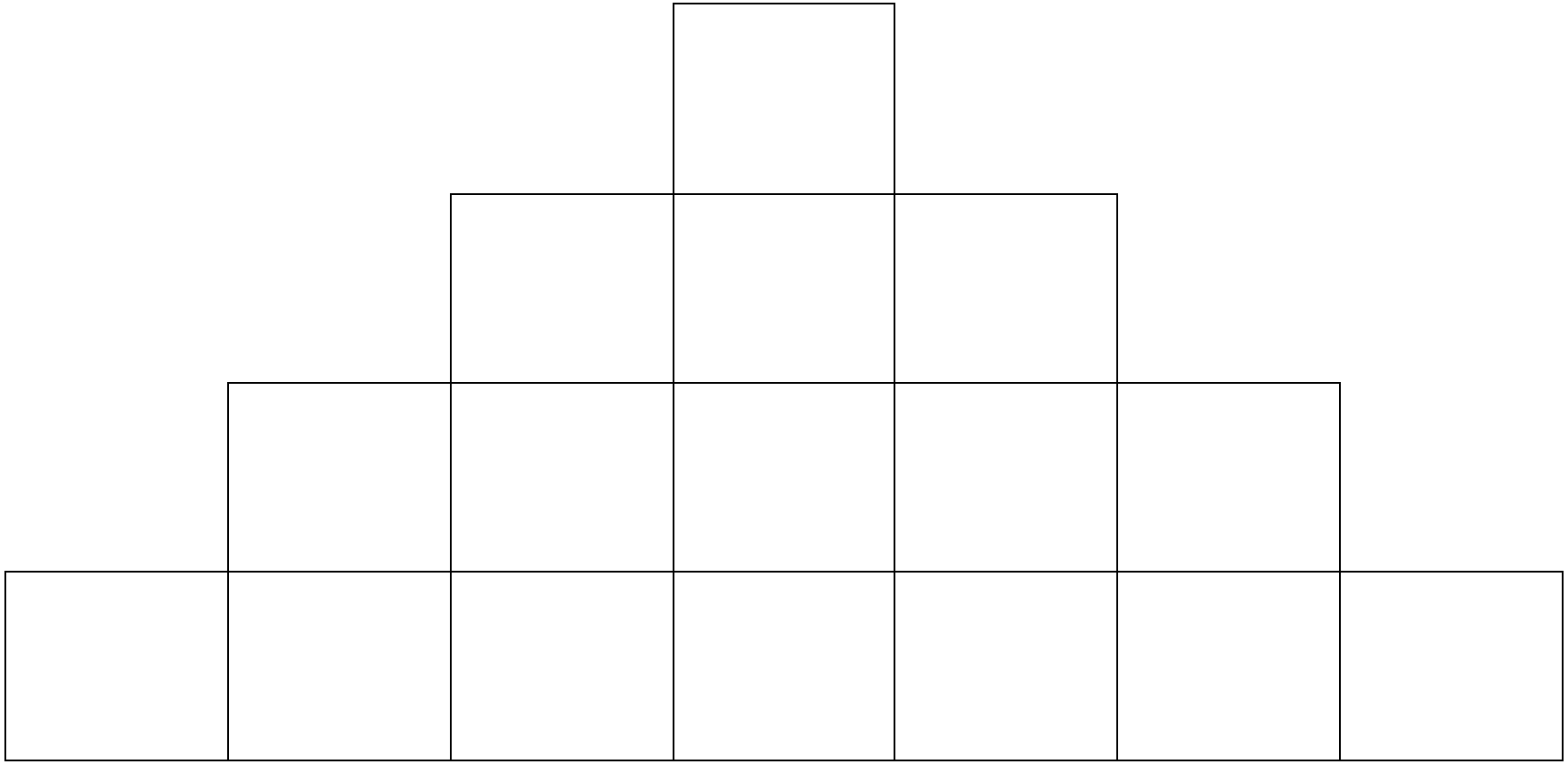
Q-Sort Instructions: Arrange the selected needs in priority order. Place highest priority needs in the first column, second priority needs in the second column, etc. Calculate the mean score of each priority, as instructed by your facilitator. Your facilitator may also wish to calculate standard deviations; standard deviations are important because they tell you how consistent or how disparate the scoring was. Those needs on which there is relatively good agreement (i.e., low standard deviations) can be set aside as high, medium or low priority needs, depending on the score. The needs that merit discussion are those on which there was NOT good agreement (i.e., higher standard deviations). In this way, the Q-Sort method can save time by eliminating the need to discuss those items on which there was greater unanimity of opinion.

Consider these criteria when sorting priorities:

- **Magnitude of Issue**: Based on data results, what is the magnitude of the issue? Compared to targets, baselines, or comparison groups, what is the magnitude of the disparity for the Kansas population or a subgroup of the Kansas population? How many people does this issue actually or potentially affect?
- **Seriousness of Consequences**: How serious are the consequences if this issue is not addressed? What is the potential for death, disease, or physical/mental disability for the Kansas population or a subgroup of the population if this issue is not addressed? What social and economic burdens on the state will appear and/or not be alleviated if this issue is not addressed?
- **Potential for Improving**: Is the issue amenable to interventions? Are potential interventions both feasible and acceptable to the public and stakeholders?

Tool #4

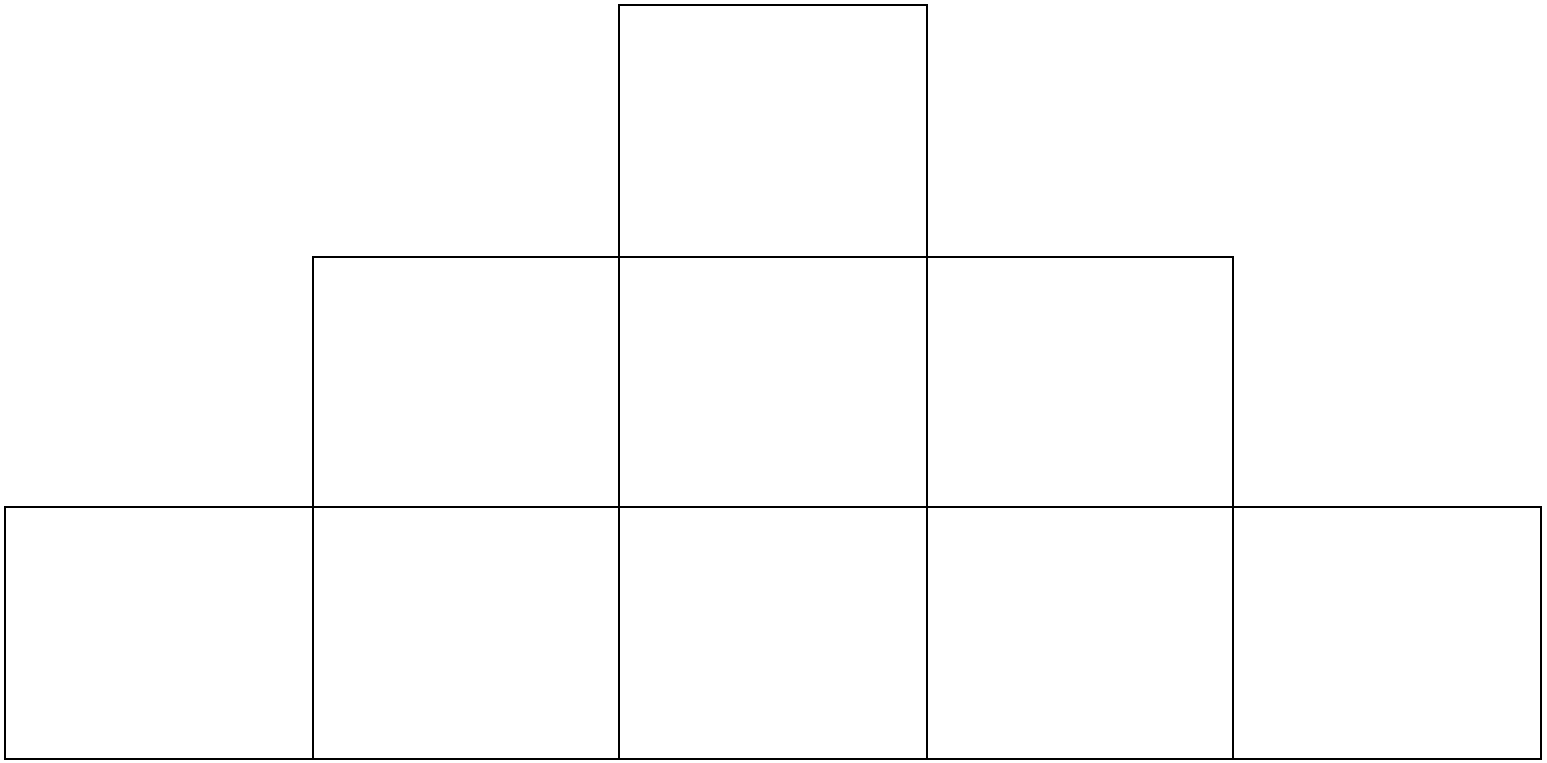
Q-Sort (for groups starting with 10-16 priorities)



The MCH Need in this Column has the Highest Priority	The MCH Needs in this Column have the Second Highest Priority	The MCH Needs in this Column have the Third Highest Priority	The MCH Needs in this Column have the Fourth Highest Priority	The MCH Needs in this Column have the Fifth Highest Priority	The MCH Needs in this Column have the Sixth Highest Priority	The MCH Need in this Column has the Lowest Priority

Tool #4

Q-Sort (for groups starting with 9 or fewer priorities)



The MCH Need in this Column has the Highest Priority	The MCH Needs in this Column have the Second Highest Priority	The MCH Needs in this Column have the Third Highest Priority	The MCH Needs in this Column have the Fourth Highest Priority	The MCH Need in this Column has the Lowest Priority

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Appendix C.3

Tool #5: Identify Actions/Strategies

MCH 2010 Needs Assessment

Background

It is not enough to agree that something is a priority. We must have reasonable strategies for addressing the issue in order for it to rise to the level of a priority in Kansas.

As discussed in the Meeting #1, the public health function is carried out in many ways, from providing services directly, to financing services, to educating, building systems, or improving data capacity. Given the priority you identified, consider possible strategies for each area. Then, consider the relative effectiveness, efficiency, and acceptability of each one and derive a total "score" for each. From this, you should be able to determine your top three approaches. Finally, having considered the various approaches, decide if you still believe this priority would rank as your "most important".

Consider possible strategies/actions within each "approach" area. Fill in the left hand column on the sheet with one example for each area.

Then, consider the effectiveness, efficiency, and acceptability of each approach area and rank the recommended strategy as **low (1)**, **medium (2)**, or **high (3)**.

From this, you should be able to identify your top three approaches.

Finally, on a scale of 1 (low) to 10 (high), tell us how important you think this problem is, now that you've considered the possible solutions.

Tool #5

Identified Priority: _____

Identify specific activities within each approach area and then rate it overall based on its effectiveness, efficiency, and acceptability to the public, legislators, providers, etc. Then, from the scores, indicate the top three approaches. Then, consider whether you would move this priority up or down on your list, given the level of approaches available to you to address the problem.

Action/Strategy	Effectiveness	Efficiency	Acceptability	Total
Provide services directly – Specific activities				
Contract with others to provide service – Specific activities				
Regulate the activity – Specific activities				
Educate public, providers, etc. – Specific activities				
Systems development – Specific activities				
Data systems improvement – Specific activities				

How does this priority rate now that you've considered solutions? _____

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Appendix C.4

Priority and Strategy Response Sheet

Feel free to comment on priorities and strategies for *any* of the population groups.

1. Reviewing the list of the top three priorities for each group, do you agree these should be the focus for enhancing the health of Kansas women, infants, children, adolescents, and children with special health care needs in partnership with families and communities from 2005 to 2010? Why or why not?

2. Choose a priority from the list and review the suggested strategies. Suggest at least one additional strategy for this priority. (You are welcome to suggest strategies for more than one priority.)

3. Review the list of priorities and suggested strategies. Who is interested, active, or already making an impact in these areas? Please list any person, organization, or program we should collaborate with or contact for more information.

4. Additional comments/suggestions:

Name _____

Appendix D.1. Pregnant Women and Infants Data Presentation

MCH 2010 Needs Assessment

To Enhance the Health of Kansas Women and Infants in Partnership with Families and Communities

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From Data to Potential Action

Maternal Health/ Prematurity	Preconceptional Health Health Behaviors Perinatal Care
Maternal Care	Prenatal Care High Risk Referral Obstetric Care
Newborn Care	Perinatal Management Neonatal Care Pediatric Surgery
Infant Health	Sleep Position Breast Feeding Injury Prevention

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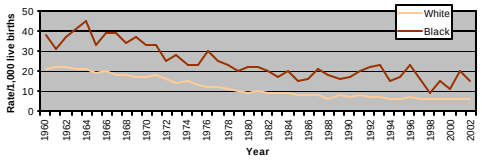
Infant Mortality

Infant Mortality Trend by Race, Kansas, 1960-2002



Other races are excluded because the numbers are to small to calculate rates.

Center for Health & Environmental Statistics

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Starting Prenatal Care in the First Trimester

Nationally

The percent of mothers who began prenatal care in the first trimester of pregnancy has risen slowly but steadily, since 1990, by 10 percent to **82.1% in 2002.**
Late (care in the last trimester) or no prenatal care declined to **3.6 percent**, and has dropped from 6.1 percent since 1990.
Improved levels of timely care were reported for most race and Hispanic origin groups for 2002.

Data Source: Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. Births: Final data for 2002. National Vital Statistics Reports; vol 52 no 10. Hyattsville, Maryland: National Center for Health Statistics. 2003.

Kansas.. ...All Live Births, 2002 **86.1%**

Race		Ethnicity	
White	86.9	Non-Hispanic	88.2
Black	78.9	Hispanic	71.1
Other	82.9		

Data Source: Center for Health and Environmental Statistics

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Infant Mortality

PPOR Map of Feto-Infant Mortality

	Fetal Death	Neonatal	Post-neonatal
500-1499 g	Maternal Health/ Prematurity		
1500+ g	Maternal Care	Newborn Care	Infant Health

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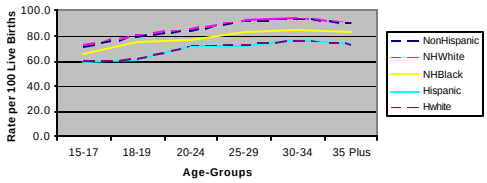
Starting Prenatal Care in the First Trimester

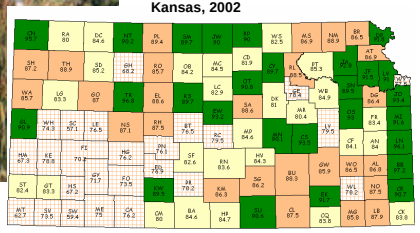
Prenatal Care Began in the First Trimester by Age-Group and Ethnicity/Race

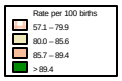


Small numbers were excluded: mother less than 15 years and of b lack Hispanic origin.

Data Source: Center for Health and Environmental Statistics

Live Birth Rates Where Prenatal Care Began in the First Trimester by County, Kansas, 2002





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Data Source: Center for Health and Environmental Statistics

Low Birth Weight (Less Than 2500 Grams)

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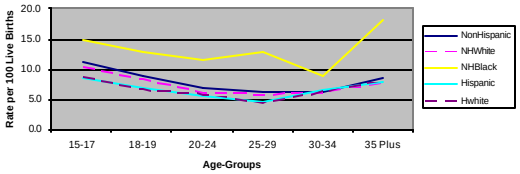
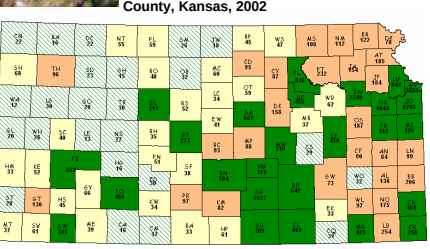
Low Birthweight by Age-Group and Ethnicity/Race, Kansas, 2002

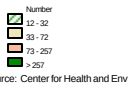


Small numbers were excluded: mother less than 15 years and of b lack Hispanic origin.

Data Source: Center for Health and Environmental Statistics

Number of Live Births Where Prenatal Care Began in the First Trimester by County, Kansas, 2002





MCH2010
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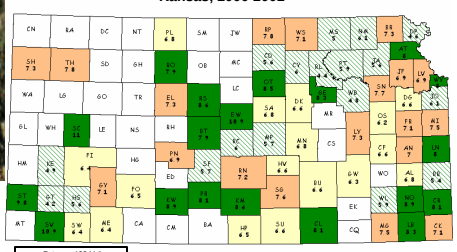
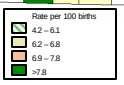
Data Source: Center for Health and Environmental Statistics

Infants Born (Rates) with Low Birth Weight (<2,500 Grams) by County, Kansas, 2000-2002





MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Data Source: Center for Health and Environmental Statistics

Low Birth Weight (Less Than 2500 Grams)

MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Nationally

- LBW increased to 7.8 percent of all live births, the highest level reported in more than three decades.
- The rate of very low birth weight (VLBW) (less than 1,500 grams) was 1.46 percent for 2002, compared with 1.44 percent for 2001.
- LBW levels were up for the both Black/African American and White births for 2002.

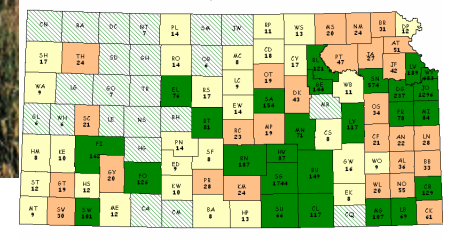
Data Source: Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. Births: Final data for 2002. National Vital Statistics Reports; vol 52 no 10. Hyattsville, Maryland: National Center for Health Statistics. 2003.

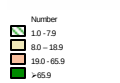
Kansas 2002 7.0/100 Births

Race		**Ethnicity**	
White	6.6	Non-Hispanic	7.0
Black	12.4	Hispanic	6.0
Other	5.6		

Data Source: Center for Health and Environmental Statistics

Number of Infants Born with Low Birth Weight (<2,500 Grams) by County, Kansas, 2000-2002





MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Data Source: Center for Health and Environmental Statistics

Preterm Births (Less Than 37 Weeks Gestation)

Nationally

- The rate of preterm births increased in 2002 to 12.1 percent of all births from 11.9 in 2001.
- While the proportion of preterm infants has risen 14 percent since 1990, the preterm rate for singleton births only has risen 7 percent, from 9.7 to 10.4 percent.
- Preterm rates increased for non-Hispanic white, non-Hispanic black, and Hispanic infants between 2001 and 2002.

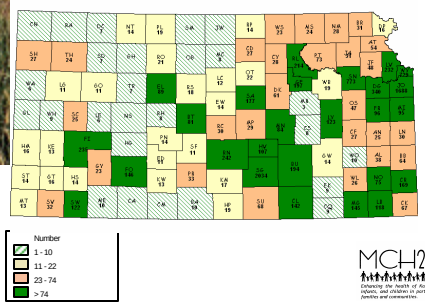
Data Source: Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Men acker F, Munson ML. Births: Final data for 2002. National Vital Statistics Reports; vol 52 no 10. Hyattsville, Maryland: National Center for Health Statistics. 2003.

Kansas 2002… 8.6/100 Births

Race		Ethnicity	
White	8.3	Non-Hispanic	8.7
Black	12.3	Hispanic	7.0
Other	7.2		

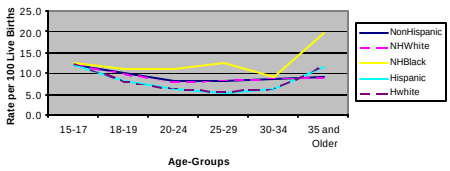
Data Source: Center for Health and Environmental Statistics

Number of Infants Born Preterm by County, Kansas, 2000-2002



Preterm Births (Less Than 37 Weeks Gestation)

Premature Birth by Age-Group and Ethnicity/Race, Kansas, 2002



Data Source: Center for Health and Environmental Statistics

Breastfeeding

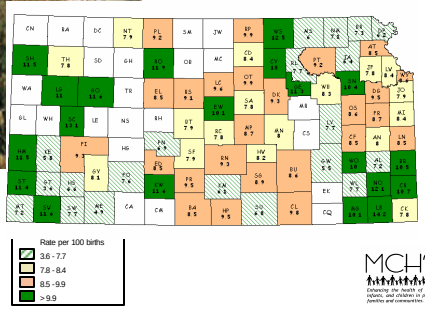
Key findings of the 2003 National Immunization Survey Regarding Breastfeeding Practices:

Fourteen states in the United States have achieved the national *Healthy People 2010 of 75% of mothers initiating breastfeeding.*

- 6 and 8 states have achieved the objective of having 50% of mothers breastfeeding their children at 6 months of age and 25% of mothers breastfeeding their children at 12 months of age, respectively.
- Only Oregon has achieved an exclusive breastfeeding rate above 25% at 6 months.
- Consistent with previous research, the NIS breastfeeding data reveal that non-Hispanic blacks and socioeconomically disadvantaged groups have consistently lower breastfeeding rates.

The American Academy of Pediatrics (AAP) recommends that an infant be breastfed without supplemental foods and liquids for the first 6 months of age (known as exclusive breastfeeding)

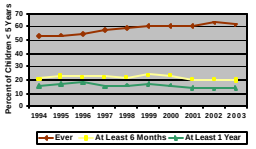
Infants Born Preterm (Rate) by County, Kansas, 2000-2002



Breastfeeding

Trends in Breastfeeding...WIC Population

Kansas



Summary of Breastfeeding by Race/Ethnicity 2003 WIC

Race/Ethnicity	% Ever Breastfed	Breastfed At Least 6 Months	Breastfed at Least 12 Months
White, Not Hispanic	64.0	19.7	13.8
Black, Not Hispanic	47.0	11.6	8.1
Hispanic	71.3	33.5	20.6
American Indian	66.3	18.1	11.5
Asian	51.0	20.3	19.9

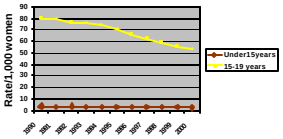
Data Source: 2003 Pediatric Nutrition Surveillance

Teen Pregnancy – National Data

1990, 2000 Comparison of Rates/1,000 women, by Race and Hispanic Origin of Women (15 -17)

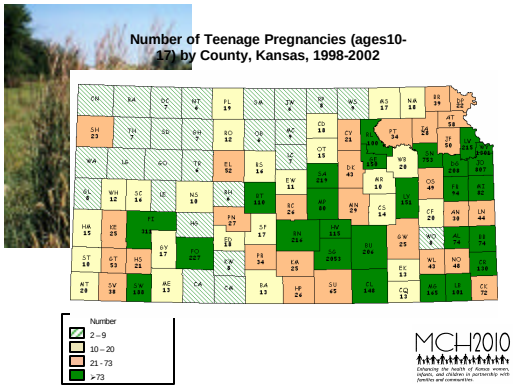
	1990	2000
Race/Ethnicity		
Non-Hispanic White	56.5	32.5
Non-Hispanic Black	165.0	100.7
Hispanic	101.0	83.1
National Rates	80.3	53.5

Trend in Pregnancies by Age-Group, 1990-2000



Ventura SJ, Abma JC, Mosher WD, Henshaw S. Estimated pregnancy rates for the United States, 1990– 2000: An Update. National vital statistics reports; vol 52 no 23. Hyattsville, Maryland: National Center for Health Statistics. 2004.

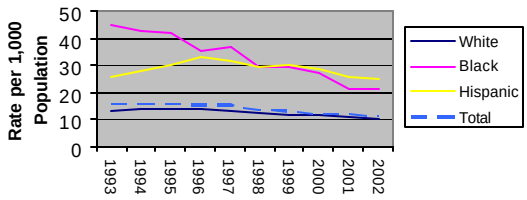
Number of Teenage Pregnancies (ages10-17) by County, Kansas, 1998-2002



Data Source: Center for Health & Environmental Statistics

Teen Pregnancy - - Kansas

Trend in Teenage Pregnancies (ages 10-17) by Race and Hispanic Origin, Kansas



Center for Health & Environmental Statistics

Teen Pregnancy – Trends

According to a Journal of Adolescent article, dated Aug, 2004.

Both delayed initiation of sexual intercourse and improved contraceptive practice among adolescents contributed evenly to the marked decline in U. S. pregnancy rates among teens 15-17 years between 1991 and 2001.

The pregnancy rate declined 33%

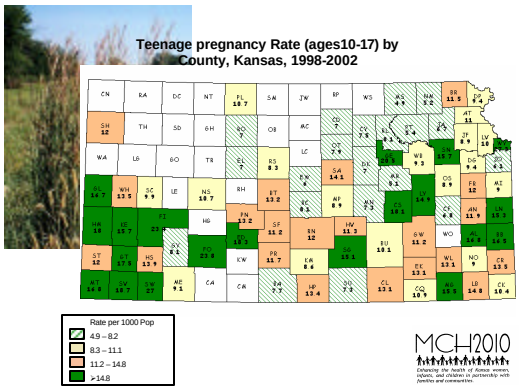
- 53% of the decline can be attributed to decreased sexual activity
- 47% to improved contraceptive use.

Progress has been made, but…in 2001

- 43% of females 15- 17 reported being sexually experienced
- Of these females 1 in 8 reported using no contraception during their last sexual experience.

J Adolescent Health. 2004 Aug;35(2):80 -90. Can changes in sexual behaviors among high school students explain the decline in teen pregnancy rates in the 1990s? Santelli JS, Abma J, Ventura S, Lindberg L, Morrow B, Anderson JE, Lyss S, Hamilton BE. National Center for Chronic Disease Prevention and Health Promotion, US Centers for Disease Control and Prevention, Atlanta, Georgia, USA. jts8@cdc.gov

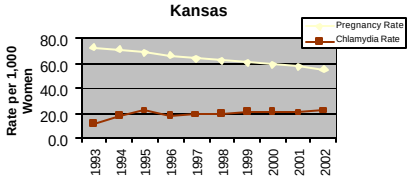
Teenage pregnancy Rate (ages10-17) by County, Kansas, 1998-2002



Data Source: Center for Health & Environmental Statistics

Teen Pregnancy - - Chlamydia

Trend in Pregnancies and Reported Chlamydia Cases in Females 15-19, Kansas



Data Source: Bureau of Epidemiology and Disease Prevention
Kansas Department of Health and Environment

Smoking During Pregnancy

***Healthy People 2010* target ….≤1% of women smoke during pregnancy**

National Data, 2002

Smoking during pregnancy dropped to 11.4 percent of all mothers, a decline of 42 percent from 1989.

Smoking rates declined for all age groups and most race and Hispanic origin groups.

12.2 percent of mothers who smoked had a low birth weight child compared with 7.5 percent of non-smokers.

Kansas, 2002

In 12.2% of live births, the mother smoked during pregnancy. This percent is slightly down from 2001 (12.6%).

Note: While prenatal smoking is believed to be somewhat underreported on the birth certificate, the trends and variations in maternal smoking based on birth certificate data have been largely corroborated by data from nationally representative surveys.

Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Munson ML. Births: Final data for 2002. National vital statistics reports; vol 52 no 10. Hyattsville, Maryland: National Center for Health Statistics. 2003.

Alcohol Use Among Women

Alcohol Use Among Women of Childbearing Age --- United States, 1991–1999

- The rate of any alcohol use (i.e., at least one drink) during pregnancy has declined since 1995 (12.8% in 1999).
- Rates of binge drinking (2.7% in 1999) and frequent drinking (3.3%) during pregnancy have not declined, and these rates also have not declined among nonpregnant women of childbearing age.
- In comparison with other pregnant women, pregnant women who reported any alcohol use, binge drinking, and frequent drinking were more likely to be aged >30 years, employed, and unmarried

Data Source: MMWR, **April 5, 2002 / 51(13);273-6**

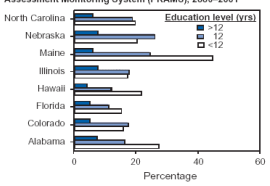
Smoking During Pregnancy

PRAMS Data

The overall prevalence of smoking during the last 3 months of pregnancy ranged from 9.0% in Hawaii to 17.4% in Maine .

Among the eight states, younger women, white or American Indian women, non-Hispanic women (except in Hawaii), women with ≤12 years of education, and women with low incomes consistently reported the highest rates of smoking during pregnancy.

FIGURE 2. Prevalence of smoking during last 3 months of pregnancy, by education level — eight states, Pregnancy Risk Assessment Monitoring System (PRAMS), 2000–2001



Data Source: MMWR Surveill Summ. 2004 Jul 2;53(4):1-13.

Postpartum Depression

PRAMS Data on Self-Reported Postpartum Depression (SRPPD), 2000

In 2000, seven states (Alaska, Louisiana, Maine, New York, North Carolina, Utah, and Washington) collected information about SRPPD

7.1% (32,176) reported severe depression after delivery and more than half (233,844) reported low to moderate depression.

- The percentage of PRAMS respondents with severe SRPPD ranged from 5.1% in Washington to 8.9% in Louisiana;
- The percentage with low to moderate depression ranged from 48.9% in New York to 62.3% in Utah
- The percentage with no depression ranged from 31.0% in Utah to 44.6% in New York

Data available at http://www.cdc.gov/reproductivehealth/PRAMS_/pramsFS_depression.htm

Alcohol Use During Pregnancy

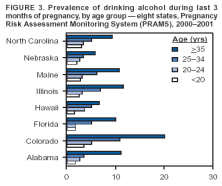
People 2010 target – <= 6% alcohol use during pregnancy

PRAMS Data

Overall, the prevalence of alcohol use during pregnancy ranged from 3.4% to 9.9%.

In seven states, women aged ≥35 years, non-Hispanic women, women with more than a high school education, and women with higher incomes reported the highest prevalence of alcohol use during pregnancy.

FIGURE 3. Prevalence of drinking alcohol during last 3 months of pregnancy, by age group — eight states, Pregnancy Risk Assessment Monitoring System (PRAMS), 2000–2001



Data Source: MMWR Surveill Summ. 2004 Jul 2;53(4):.

Postpartum Depression

PRAMS Data on Self-Reported Postpartum Depression (SRPPD), 2000

Women who were most likely to report severe depression

- Were less than 20 (11.4%)
- Were of the black race (9.5%)
- Had fewer than 12 years of education (10.3%)
- Were Medicaid recipients (10.5%)
- Delivered low-birth-weight babies (11.4%)
- Experienced physical abuse during pregnancy (21.9%)

Data available at http://www.cdc.gov/reproductivehealth/PRAMS_/pramsFS_depression.htm

Congenital Anomalies

Nationally, 2002,

The leading cause of infant mortality, **Congenital malformations, deformations and chromosomal abnormalities**, accounted for 20.2 percent of all infant deaths. The infant mortality rate for this cause increased slightly from 136.9 infant deaths per 100,000 live births in 2001 to 140.7 in 2002, but the increase was not statistically significant

Kochanek KD, Smith BL. Deaths: Preliminary Data for 2002. National vital statistics reports; vol. 52, no. 13. Hyattsville, Maryland: National Center for Health Statistics. 2004.

Kansas, 2002

In Kansas, congenital anomalies is also the leading cause of infant mortality (63 deaths) at a rate of 164.3/100,000 population.

Sudden Infant Death Syndrome (SIDS)

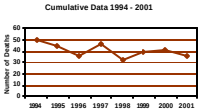
State Child Death Review Board Data, 2001 Annual Report

In 2001, among infant deaths classified SIDS (36)

83.3% were from the white race, and 16.7% were from the black race.

58.3% were males and 41.7% were females.

36.1 were 3 months and 27.8 were 4 months of age at death



Congenital Anomalies

In 2002, there were 519 live births with a congenital anomaly in Kansas

	Number	% Died <28 Days
PDA	73	2.7
Heart malformations, except PDA	87	10.3
Other circulatory/respiratory anomalies	27	22.2
Other urogenital anomalies	51	--
Cleft lip/palate	41	14.6
Polydactyly/Syndactyly/Adactyly	44	4.5
Other musculoskeletal/integumental anomalies	90	4.4

Data Source: Center for Health & Environmental Statistics

Undocumented Population

National

The INS estimates that the total unauthorized immigrant population residing in the United States in January 2000 was 7.0 million which has increased from 3.5 million in 1990

Kansas

There is an estimated 49,000 (2000) unauthorized immigrant population or 0.7% of the national total.

This has increased from 14,000 (1990) unauthorized immigrants or 0.4% of the national total.

Estimates of the Unauthorized Immigrant Population Residing in t he United States: 1990 to 2000 , Office of Policy and Planning U.S. Immigration and Naturalization Service

Sudden Infant Death Syndrome (SIDS)

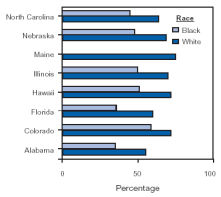
People 2010 target – ≥70% of infants put to sleep in the back position.

PRAMS Data

The overall prevalence of mothers using the recommended back sleep position for their infants ranged from 49.7% in Alabama to 74.8% in Maine

Among all eight states, use of the back sleep position was lowest among younger women, black women, women with lower levels of education, and women with low incomes; ethnic differences in sleep position varied by state

FIGURE 5. Prevalence of infant sleeping position on back, by maternal race — eight states, Pregnancy Risk Assessment Monitoring System (PRAMS), 2000–2001



Data Source: MMWR Surveill Summ. 2004 Jul 2;53(4):1-13.

Communication – English as a Second Language

Kansas Children and Families (Bureau of Children, Youth & Families) Data, 2003

Percent of clients with English as a secondary language from grant funded programs when this question was answered

Family Planning Grants	13.5%
Maternal Child Health Grants	
Prenatal	33.3%
Healthy Start	17.5%
Child Health	20.0%
School Clinic Grants	7.8%

Data Source: PROGRESS

MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Conclusion

Dads are Important, Too!

Appendix D.2. Children and Adolescents Data Presentation

MCH 2010 Needs Assessment

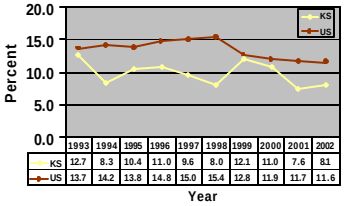
To Enhance the Health of Kansas Children and Adolescents in Partnership with Families and Communities

MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Insurance Coverage

Uninsured Children Under 18 Years Old



	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
KS	12.7	8.3	10.4	11.0	9.6	8.0	12.1	11.0	7.6	8.1
US	13.7	14.2	13.8	14.8	15.0	15.4	12.8	11.9	11.7	11.6

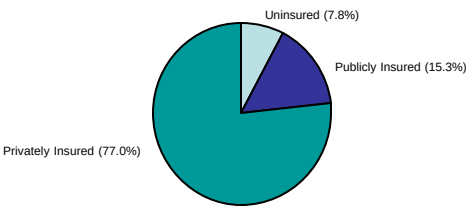
Year

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplements.

MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Insurance Coverage

Distribution of Kansas Children by Insurance Status, 2001
Children under 19 years old



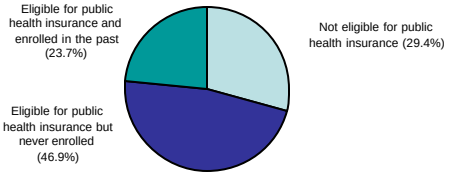
Note: all children with non-missing data are included (n=7,490).

Source: Uninsured Children in Kansas: Who Are They and How Could They Be Reached? October 2003, Kansas Health Institute.

MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Insurance Coverage

Distribution of Uninsured Children in Kansas
by Eligibility and Enrollment in Public Health Insurance, 2001
Children under 19 years old



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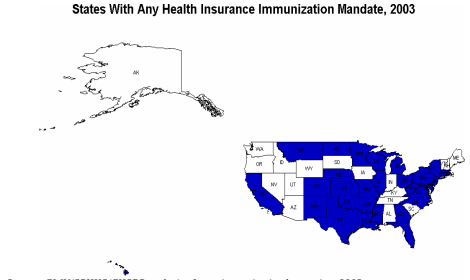
MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Mandated Preventive Care

States With Any Health Insurance Immunization Mandate, 2003

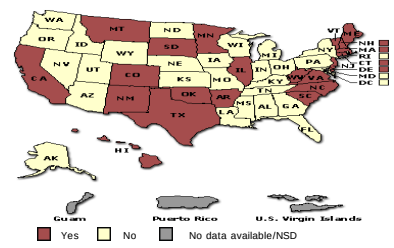


Source: GWU/SPHHS/CHSRP analysis of state immunization laws, winter 2003

MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

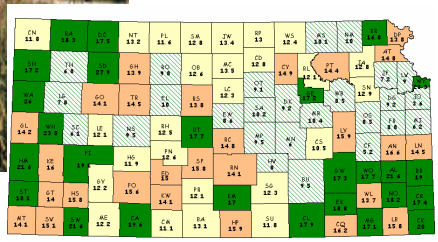
Mandated Benefits

State Mandated Benefits: Mental Health Parity, 2002



Source: Kaiser Family Foundation State Health Facts Online

Children in Poverty - 17 and Under, 1999



Rate per 100 Pop
3.6 - 10.4
10.5 - 13.6
13.7 - 16.6
> 16.6

Data Source: U. S. Census 2000

Undocumented Population

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Estimates of the Unauthorized Immigrant Population Residing in t he United States: 1990 to 2000 , Office of Policy and Planning U.S. Immigration and Naturalization Service , available at http://uscis.gov/graphics/shared/aboutus/statistics/Ill_Report_1211.pdf , downloaded July, 2004

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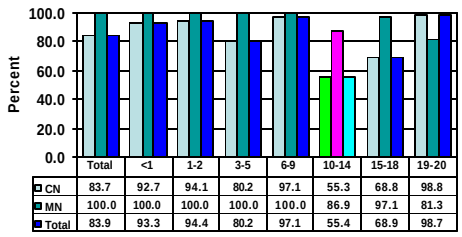
School Clinic Grants	7.8%

Data Source: PROGRESS

Utilization of Health Services

KAN BE HEALTHY SCREENING RATIO



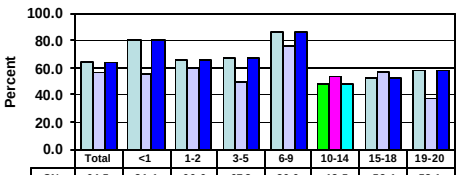
	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	83.7	92.7	94.1	80.2	97.1	55.3	68.8	98.8
MN	100.0	100.0	100.0	100.0	100.0	86.9	97.1	81.3
Total	83.9	93.3	94.4	80.2	97.1	55.4	68.9	98.7

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

Utilization of Health Services

KAN BE HEALTHY PARTICIPANT RATIO



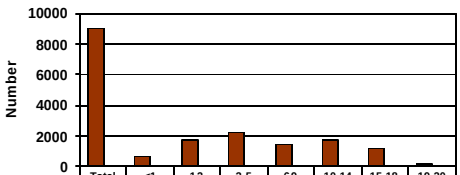
	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	64.5	81.1	66.6	67.8	86.6	48.5	53.1	58.1
MN	56.4	56.0	60.0	50.0	76.7	54.09	57.14	37.5
Total	64.4	81.0	66.6	67.8	86.6	48.5	53.1	58.0

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

Utilization of Health Services

KAN BE HEALTHY
Number of eligible referred for corrective treatment



	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	9003	597	1749	2161	1459	1744	1148	145
MN	21	1	0	1	3	13	2	1

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

Utilization of Health Services

KAN BE HEALTHY

Number of eligible receiving any dental services

	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	54291	18	1253	12275	14898	14910	9202	1735
MN	71	0	0	6	19	26	19	1

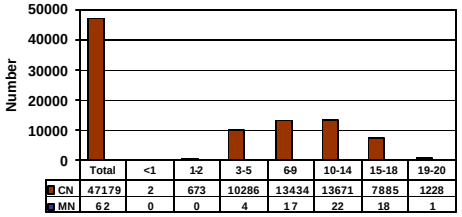
Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

Utilization of Health Services

KAN BE HEALTHY

Number of eligible receiving preventable dental services



	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	47179	2	673	10286	13434	13671	7885	1228
MN	62	0	0	4	17	22	18	1

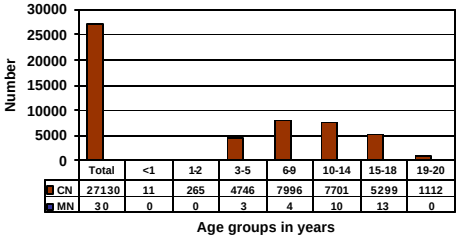
Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

Utilization of Health Services

KAN BE HEALTHY

Number of eligible receiving dental treatment services



	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	27130	11	265	4746	7996	7701	5299	1112
MN	30	0	0	3	4	10	13	0

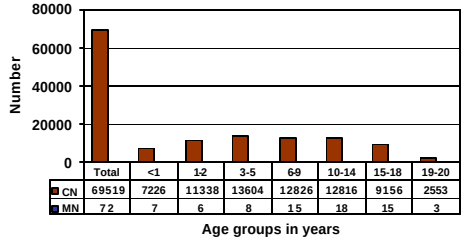
Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

Utilization of Health Services

KAN BE HEALTHY

Total number of eligible enrolled in managed care arrangements



	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	69519	7226	11338	13604	12826	12816	9156	2553
MN	72	7	6	8	15	18	15	3

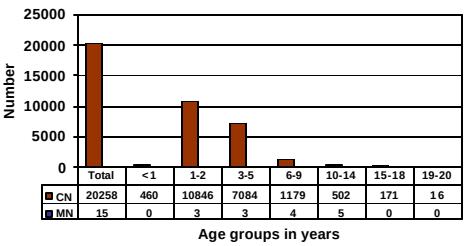
Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

Utilization of Health Services

KAN BE HEALTHY

Total number of screening blood lead tests



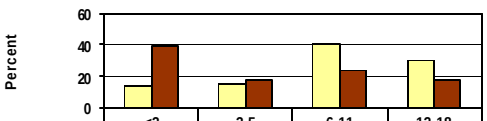
	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	20258	460	10846	7084	1179	502	171	16
MN	15	0	3	3	4	5	0	0

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

Utilization of Health Services

SCHIP vs. Medicaid



	<3	3-5	6-11	12-18
SCHIP	14.5	15.5	40.9	30.2
Medicaid	39.8	18.4	23.9	17.9

Age groups in years

SCHIP Tends to Enroll Older Children Than Medicaid (Age <19 yrs.)

Note: SCHIP (State Children's Health Insurance Program) - HealthWave in Kansas
Source: Findings from theHealthWave Evaluation Project. Research Brief, Kansas Health Institute, Se ptember 2003

SCHIP Families Have Higher Education, Greater Income, and Are More Likely to Have Two Parents

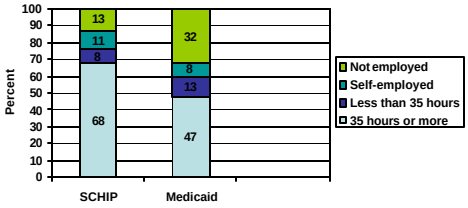
	SCHIP	Medicaid
Educational Attainment of Head of Household		
Less than High School	6%	9%
High School Graduate	58%	65%
Some College	22%	20%
College Graduate or Higher	14%	6%
Family Income <150% of Federal Poverty Level*	68%	81%
Number of Parents in Household		
Two	55%	45%
One	45%	54%

*In 2001, 150% of the Federal Poverty Level was $26,475 for a family of four.
Totals may not sum to 100% because of rounding.

Source: Findings from the HealthWave Evaluation Project. Research Brief, Kansas Health Institute, September 2003

Utilization of Health Services

Most Parents of Public Health Insurance Enrollees Are Employed



Source: Findings from the HealthWave Evaluation Project. Research Brief, Kansas Health Institute, September 2003

ASTHMA

National Data - Children Under 18 years

- More than 4 million children have had an asthma attack in the past 12 months (5.8%).
- 12.2% of children have been diagnosed with asthma.
- Boys (13.9%) are more likely than girls (10.4%) to be
- Children in poor families(16%) are more likely than children infamilies that are not poor (11%)
- When a single race was reported, black or African American children (8.6%) were more likely to have a asthmatic attack in the past 12 months than white children (5.2%)
- In the Hispanic population, 4.4% had a asthma attack in the past12 months.

Data Source: National Health Survey, 2002

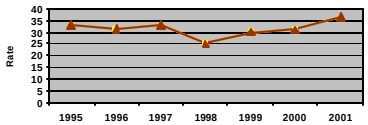
ASTHMA

Kansas Data – 1-4 AgeGroup

This age-group has the highest rates of asthma hospitalizations

In 2001 the rate/10,000 population for white children was 27.5 c ompared to 71.2 for black/African American children

Trend in Asthma Hospitalizations per 10,000 Population ages 1 through 4

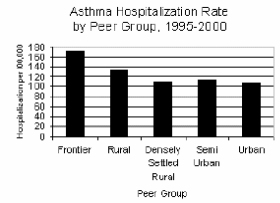


Data Source: Kansas Hospital Association, Kansas Information forCommunities

ASTHMA

Kansas Data – All Age Groups

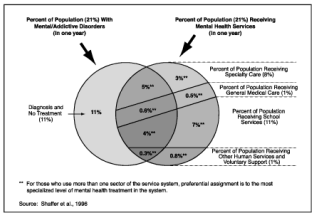
The rate of asthma hospitalizations is greatest in the frontier counties followed by the rural counties, 1995-2000



Data Source: Kansas Hospital Association, Kansas Information forCommunities

Behavioral Health

Figure 2-6b. Annual prevalence of mental/addictive disorders for children



Data Source: Mental Health: A Report from the Surgeon General, available at http://www.mentalhealth.samhsa.gov/features/surgeongeneralreport/home.asp

SELF-HARM HOSPITALIZATIONS

Emergency Department Data, United States, 2000

National Study - NEISS - AIP Data

- An estimated 264,108 persons were treated in the ED for non fatal self inflicted injuries (95.9/100,000)
  - Females 15-19 (322.7/100,000)
  - Females 20-24 (261.5/100,000)
- 65% of self inflicted injuries resulted from poisonings
- 25% were attributed to injuries with a sharp instrument
- 60% were probable suicide attempts

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SELF-HARM HOSPITALIZATIONS

In Kansas, 2001

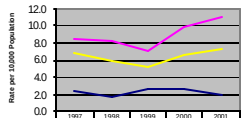
Adolescents ages 15-19 have the highest rate of self-harm hospitalizations among all age groups.

For Children and adolescents ages 5 to 24

The female to male ratio was 2.14.

In 88.6% of self-harm hospitalizations, drugs were the method of choice.

Trend in Self-Harm Hospital Discharges by Age-Group, Kansas, 1997 - 2001



	1997	1998	1999	2000	2001
10 to 14	2.3	1.8	2.5	2.6	1.8
15 to 19	8.4	8.2	7.1	9.9	11.0
20 to 24	6.7	5.8	5.2	6.6	7.3

Data Source: Kansas Hospital Association, Office of Health Care Information

Completed Suicides

In Kansas, suicide was the second leading cause of death for adolescents aged 15 to 24 (1998-2002).
In 2002, 62 adolescents ages 15 – 24 completed suicide (15.0 per 100,000).

For national comparison, the most recent final data available is for the year 2001. In Kansas, 2001, adolescents ages 15-19 completed suicide at a rate of 15.2/100,000 population compared to 9.9/100,000 nationally.

In Kansas, 2001-2002 46 adolescents ages 15-19 completed suicide (11.1/100,000 population) which compares with 39 for 1999-2000 (9.2/100,000 population). These rates are not significantly different.

Data Source: Center for Health & Environmental Statistics

Illegal Drugs

YRBSS Data

A national school-based survey conducted by CDC among students in grades 9–12 during February–December 2003.

22.4% had used marijuana one or more times during the 30 days preceding the survey.

4.1% had used a form of cocaine one or more times during the 30 days preceding the survey

3.9% sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high one or more times during the 30 days preceding the survey

7.6% used methamphetamines one or more times during their lifetime.

11.1% used ecstasy one or more times during their lifetime.

Alcohol Use

YRBSS Data

A national school-based survey conducted by CDC among students in grades 9–12 during February–December 2003.

44.9% drank one or more drinks of alcohol on one or more days during the 30 days preceding the survey.

28.3% drank 5 or more drinks of alcohol in a row on one or more days in the 30 days preceding the survey.

30.2% rode with a driver who had been drinking alcohol in a car or other vehicle one or more times during the 30 days preceding the survey.

12.1% drove after drinking alcohol in a car or other vehicle one or more times during the 30 days preceding the survey.

Suggestions for Alcohol Usage Indicators for Kansas from KDOT crash, person data
1) Percentage of adolescents ages 14-18 who rode with a driver who had been drinking alcohol.
2) Percentage of adolescents ages 14-18 who drove after drinking alcohol.

Alcohol and Drug Use

Kansas Bureau of Investigation Juvenile Arrest Statistics, 2003

Age<=17 Years

Drug Arrests		Alcohol Arrests	
Narcotic Drug Violation	1798	DUI	356
Drug Equipment Violation	169	Liquor Violations	1649
Total Drug arrests	1967	Drunkenness	1
		Total Alcohol Arrests	2006

Note: Data available from all agencies except Topeka, Kansas

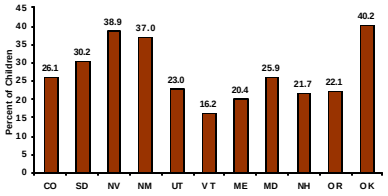
Youth Tobacco Use

	GRADES 6–8		*GRADES 9–12*	
	Current Cigarette Smoking	Current Any Tobacco Use	Current Cigarette Smoking	Current Any Tobacco Use
National*	11.0%	15.1%	28.0%	34.5%
KS†	8.1%	12.0%	26.1%	33.6%
Boys†	8.0%	13.2%	24.7%	37.2%
Girls†	7.9%	10.3%	27.5%	29.7%

Current Cigarette Smoking = smoked cigarettes on= 1 of the 30 d ays preceding the survey.
Current Any Tobacco Use = current use of cigarettes or smokeless tobacco or pipes or bidis or cigars or kreteks on= 1 of the 30 days preceding the survey.
Sources: *National Youth Tobacco Survey, 2000, †Kansas Youth Tobacco Survey, 2000

Oral Health

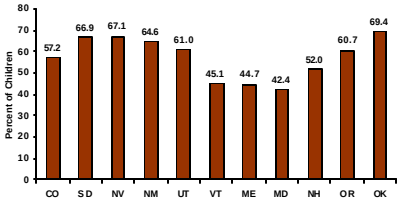
Prevalence of Untreated Decay in 3rd Grade Children Stratified by State



Note: KS data pending.
Source: Association of State and Territorial Dental Directors 2003-2004

Oral Health

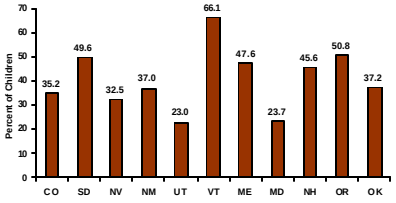
Prevalence of Caries Experience in 3rd Grade Children Stratified by State



Note: KS data pending.
Source: Association of State and Territorial Dental Directors 2003-2004

Oral Health

Prevalence of Dental Sealants in 3rd Grade Children Stratified by State



Note: KS data pending.
Source: Association of State and Territorial Dental Directors 2003-2004

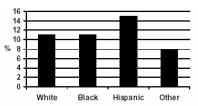
Overweight Among Adolescents

National (YRBSS, 2003) /Kansas (YTS, 2002-2003) Comparison

	Kansas	National
At risk of becoming overweight	13.6%	15.4%
Overweight	11%	13.5%
Females	7%	9.4%
Males	15%	17.4%

The percent of overweight adolescents was substantially higher among Hispanics than other race/ethnic groups as shown in Figure 3.

Figure 3.

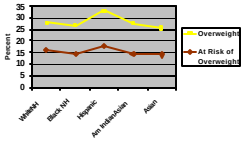


Overweight Among Children

Pediatric Nutrition Surveillance Data (WIC) among children 2-4 years of age

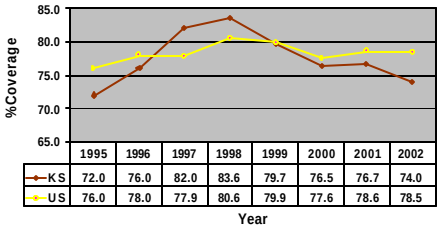
	Kansas (2003)	National(2002)
At risk of becoming overweight	16.0%	15.4%
Overweight	12.6%	14.3%

The percent of at risk of becoming overweight and overweight was higher among Hispanics than other race/ethnic groups as shown in the chart below.



Immunization Coverage

National Immunization Survey Rates for 4:3:1 Series
Children 19-35 Months

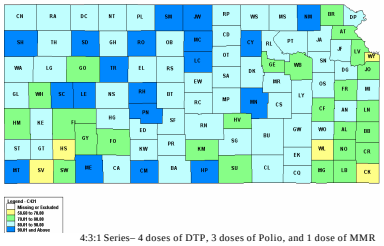


	1995	1996	1997	1998	1999	2000	2001	2002
KS	72.0	76.0	82.0	83.6	79.7	76.5	76.7	74.0
US	76.0	78.0	77.9	80.6	79.9	77.6	78.6	78.5

Year

Retrospective Immunization Coverage Survey

1998-1999 Results (School Year 2002-2003) for 4:3:1 Series (%)
Kindergarteners at the age of 2 years



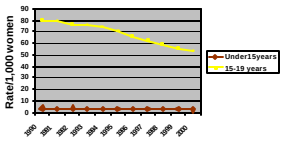
4:3:1 Series– 4 doses of DTP, 3 doses of Polio, and 1 dose of MMR

Teen Pregnancy – National Data

1990 -2000 Comparison of Rates/1,000 women, by Race and Hispanic Origin of Women (15 - 17)

	1990	2000
Race/Ethnicity		
Non-Hispanic White	56.5	32.5
Non-Hispanic Black	165.0	100.7
Hispanic	101.0	83.1
National Rates	80.3	53.5

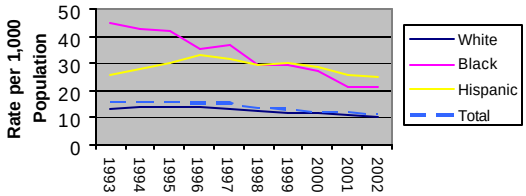
Trend in Pregnancies by Age-Group, 1990-2000



Ventura SJ, AbmaJC, Mosher WD, Henshaw S. Estimated pregnancy rates for the United States, 1990 -2000: An Update. National vital statistics reports; vol52 no 23. Hyattsville, Maryland: National Center for Health Statistics. 2004.

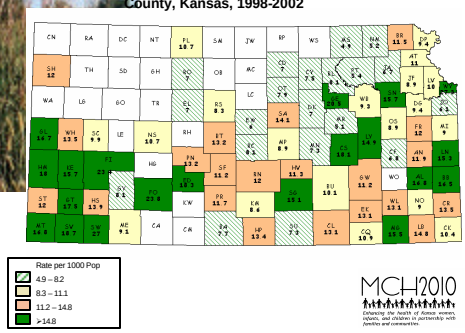
Teen Pregnancy - - Kansas

Trend in Teenage Pregnancies (ages 10-17) by Race and Hispanic Origin, Kansas



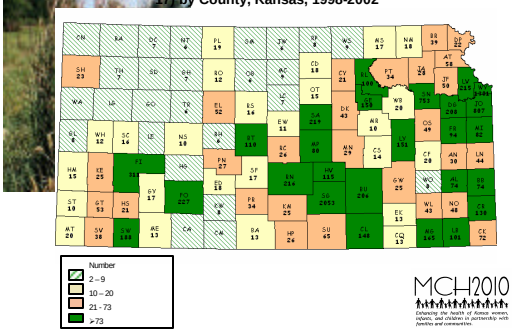
Data Source: Center for Health & Environmental Statistics

Teenage pregnancy Rate (ages10-17) by County, Kansas, 1998-2002



Data Source: Center for Health & Environmental Statistics

Number of Teenage Pregnancies (ages10-17) by County, Kansas, 1998-2002



Data Source: Center for Health & Environmental Statistics

Teen Pregnancy – Trends

According to a Journal of Adolescent article, dated Aug, 2004.

Both delayed initiation of sexual intercourse and improved contraceptive practice among adolescents contributed evenly to the marked decline in U. S. pregnancy rates among teens 15-17 years between 1991 and 2001.

The pregnancy rate declined 33%

- 53% of the decline can be attributed to decreased sexual activity
- 47% to improved contraceptive use.

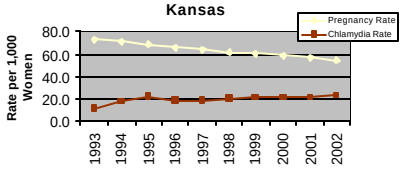
Progress has been made, but…in 2001

- 43% of females 15-17 reported being sexually experienced
- Of these females 1 in 8 reported using no contraception during their last sexual experience.

J Adolesc Health. 2004 Aug;35(2):80-90. Can changes in sexual behaviors among high school students explain the decline in teen pregnancy rates in the 1990s? Santelli JS, Abma J, Ventura S, Lindberg L, Morrow B, Anderson JE, Lyss S, Hamilton BE. National Center for Chronic Disease Prevention and Health Promotion, US Centers for Disease Control and Prevention, Atlanta, Georgia, USA. jts8@cdc.gov

Teen Pregnancy - - Chlamydia

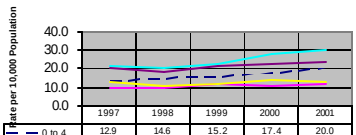
Trend in Pregnancies and Reported Chlamydia Cases in Females 15-19, Kansas



Data Source: Bureau of Epidemiology and Disease Prevention
Kansas Department of Health and Environment

Unintentional Injuries

Trend in Unintentional Injury Hospital Discharges by Age-Group, Kansas, 1997 - 2001



	1997	1998	1999	2000	2001
0 to 4	12.9	14.6	15.2	17.4	20.0
5 to 9	9.3	8.9	11.4	10.7	11.3
10 to 14	11.9	10.7	11.4	13.8	12.9
15 to 19	21.2	19.5	22.0	27.6	29.4

Data Source: Kansas Hospital Association, Office of Health Care Information

Safety Belt Usage Rates

Kansas Department of Transportation Data :
Kansas Child Observational Safety Belt Restraint Usage Rates (Percentage %)

	1998	1999	2000	2001	2002	2003
Children (age 4-14)	**59**	**57**	**55**	**52**		
Children (age < 4)	**80**	**81**	**81**	**92**		
Children (age 10-14)					*	*44*
Children (age 5-9)					*	*45*
Children (age 0-4)					*	*79*

Behavior Risk Factor Surveillance System Survey Data, Kansas, 2001

Respondents reported

- 89% of children aged 0-3 used a car safety seat
- 23% of children aged 4-8 used a booster seat.
- 58% of children 4-8 wore a seatbelt

Appendix D.3. CSHCN Data Presentation

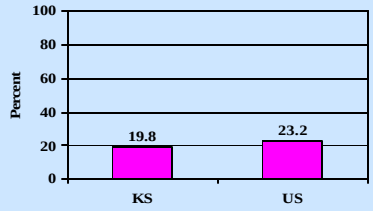
MCH2010
Enhancing the health of Kansas women, infants, and children in partnership with families and communities.

Children with Special Health Care Needs (CSHCN)

Jamie S. Kim, MPH
Kansas Department of Health and Environment
August 16, 2004

Child Health Indicator

CSHCN 3. Percent of CSHCN whose health condition consistently and often greatly affect their daily activities.



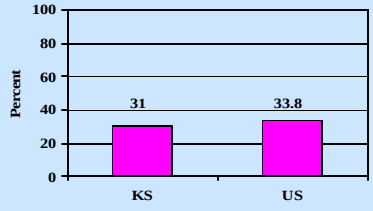
Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

- Health Conditions (Q28): Any physical, mental, learning and developmental conditions or problems.
- Affect their daily activities (Q29): Affect ability to do things other children (his/her) age do.
- Consistently (Q29): How often child has health conditions affected (his/her) ability to do things other children (his/her) age do: never, sometimes, usually, always?
- Greatly (Q30): Do child's health conditions affect (his/her) ability to do things: a great deal, some, or very little?
- Q28, Q29, Q30

Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Coverage Indicator

CSHCN 7. Percent of currently insured CSHCN with coverage that is not adequate.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

- Adequate insurance: Insurance that covers costs of needed services, including: mental health, dental care, age-appropriate well-child checks, durable medical equipment, non-durable medical supplies, care coordination, prescriptions, speciality care, related therapies (e.g., PT, OT, speech/language, audiology), in-home nursing.

Source: M&M project indicators for the CSHCN Performance measures.

- Adequate insurance: Insurance offers benefits or covers services that meet his/her needs (i.e., Medical care as well as other kinds of care like dental care, mental health services, physical, occupational, or speech therapies, and special education services.)
- Q44, Q45h, Q45i, Q46c, Q100, Q101, Q102, Q104, Q106, Q108, Q115

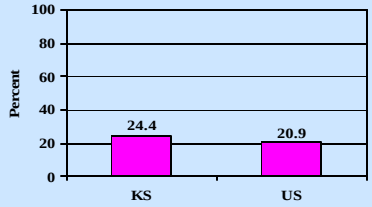
Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

- Communication Power: Is this measure communicated easily? Would it be understood what it measure means?
- Proxy Power: Does this indicator measure the most important outcomes and efforts related to your population group?
- Data Power: Is the data both available and credible? Is quality data available on a consistent and timely basis?

Example: Low Birth Weight

Impact on Family Indicator

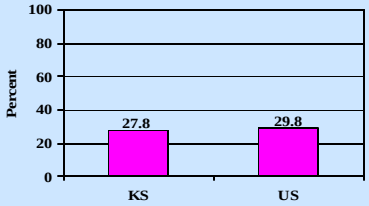
CSHCN 15. Percent of CSHCN whose families experienced Financial problems due to child's health needs.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

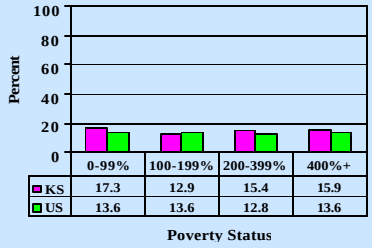
Impact on Family Indicator

CSHCN 17. Percent of CSHCN whose health needs caused Family members to cut back or stop working



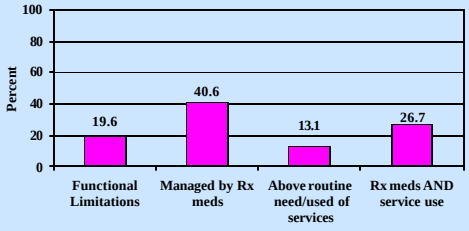
Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

KS CSHCN Household Poverty Status



Source: National CSHCN Survey, 2001 (Age 0-17 yrs.)

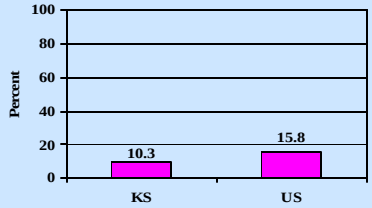
KS CSHCN by Complexity



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Child Health Indicator

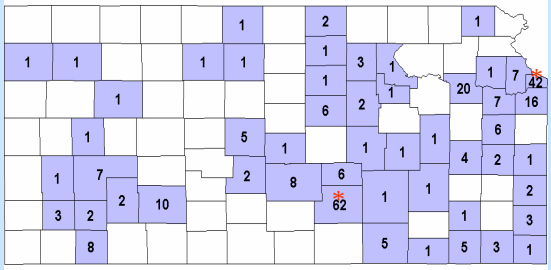
CSHCN 4. Percent of CSHCN with 11 or more days of school absences due to illness.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Children with Cerebral Palsy Served by SHS, FY2004

Total (274)

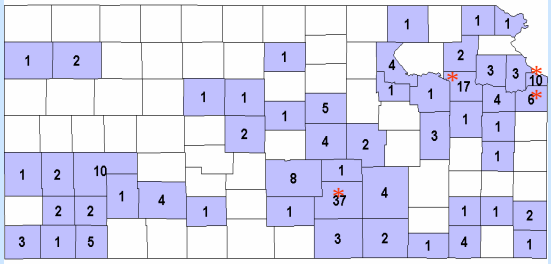


ICD 9 Codes: 342.00 -344.99

* Location of Cerebral Palsy Clinic

Children with Cleft Lip/Cleft Palate Served by SHS

FY2004 Total (178)

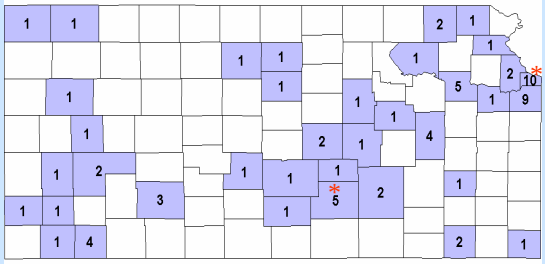


ICD 9 Codes: 749.00 – 749.25

* Location of Cleft Lip/Cleft Palate Clinic

Children with Spina Bifida Served by SHS

FY2004 Total (76)

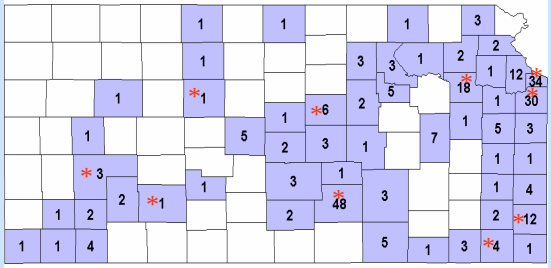


ICD 9 Codes: 741.00 – 741.99

* Location of SpinaBifida Clinic

Children with Cardiology Special Needs Served by SHS

FY2004 Total (266)



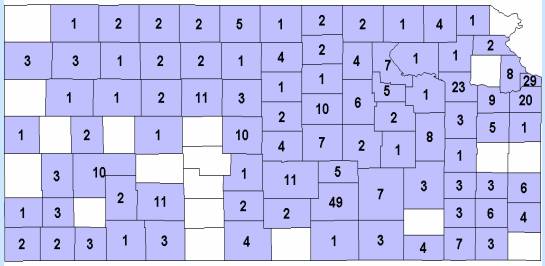
ICD 9 Codes: 390.00 – 459.99 and 745.00 – 747.99

* Location of Pediatric Cardiology Clinic

MCH2010

CSHCN primary Care Providers

(Total 405)



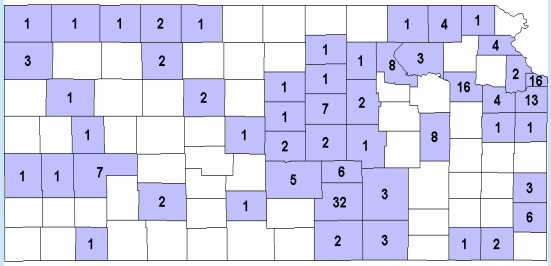
This map displays number of primary care providers listed in KDHE Services for CSHCN database.

Notes: 1. All providers are not necessarily currently providin g care to CSHCN.
2. Specialities included are Pediatrics, Internal Medicine, and Family Practice /General Practice.

MCH2010

CSHCN Dental Providers

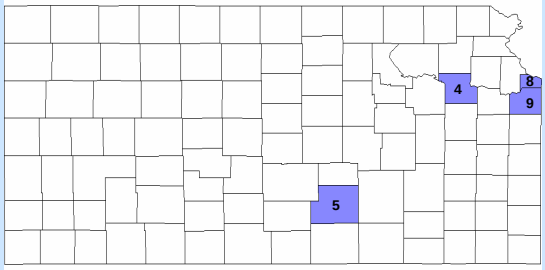
(Total 193)



This map displays number of dental providers listed in KDHE Services for CSHCN database.

Notes: 1. All providers are not necessarily currently providin g care to CSHCN.
2. Specialities included are General Dentistry/Treatment, and Orthodontics.

CSHCN Pediatric Cardiologists
(Total 26)

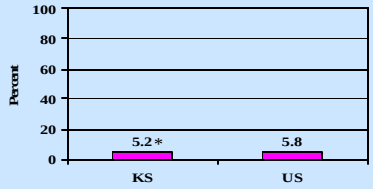


This map displays number of dental providers listed in KDHE Services for CSHCN database.

Notes: All providers are not necessarily currently providing care to CSHCN.

Transition

CSHCN22. Percent of youth with special health care needs who received the services necessary to make transition to all aspects of adult life.

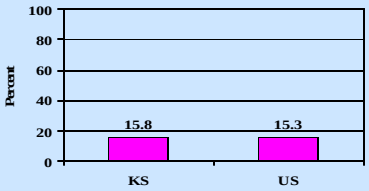


* This estimate does not meet the National Center for Health Statistics standard for reliability or precision.

Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Transition

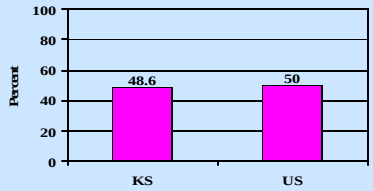
CSHCN22a. The child receives guidance and support in the transition to adulthood.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Transition

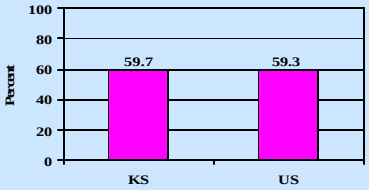
CSHCN22ai. Doctors have talked about changing needs.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Transition

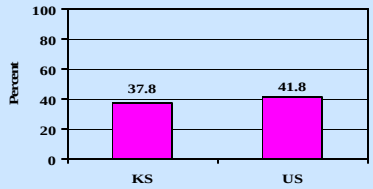
CSHCN22aii. The child has a plan for addressing changing needs.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Transition

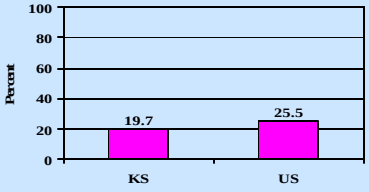
CSHCN22aiii. Doctors discussed shift to adult provider.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Transition

CSHCN22b. The child has received vocational or career training.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

- Youth (Q74a): Children 13 years old or older.
- Transition (Q74a – 74d):

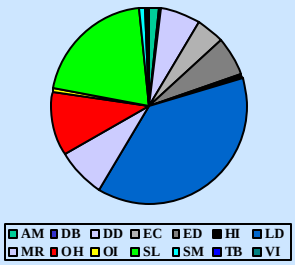
  1. Change in health care needs when becomes an adult.

  2. Any vocational or career training to help prepare for a job when becomes an adult.

  etc…
- Doctor (Q42 and Q43): a general doctor, pediatrician, specialist, nurse practitioner, or physician's assistant.

Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

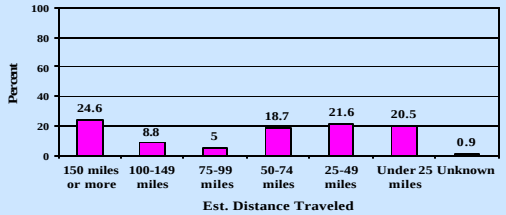
Percent of CSHCN who are receiving support services at the public school (13.85%)



Source: http://www.kansped .org/ksde/mis/FY04Prevelance.html

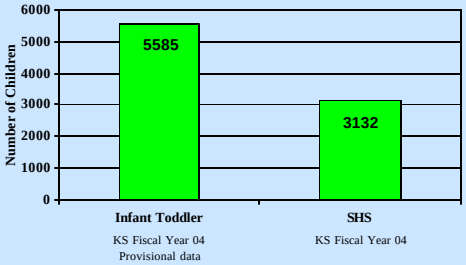
Access to Care Indicator

CSHCN 57. Percent of CSHCN specialists who have patients Travel to See Specialist.



Source: SHS Provider Survey, 1997

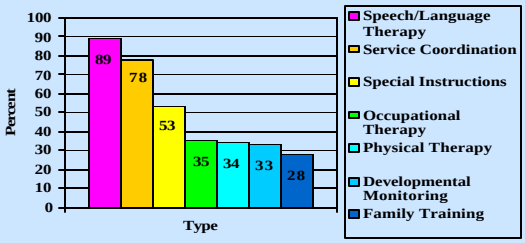
Children (Age 0 -3 yrs.) Served by Infant Toddler and SHS Programs



Source: BCYF, KDHE

Children (age 0 -3) and families who ever Received Each type of service in EI

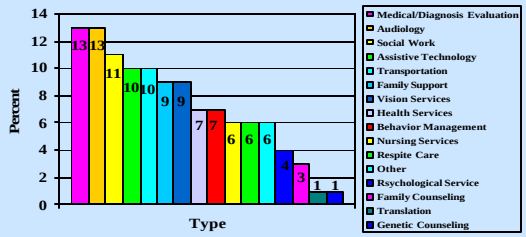
(services received by 20% or more of children and families)



Source: Kansas Early Intervention Longitudinal Study (1999–2002).

Children (age 0 -3) and families who ever Received Each type of service in EI

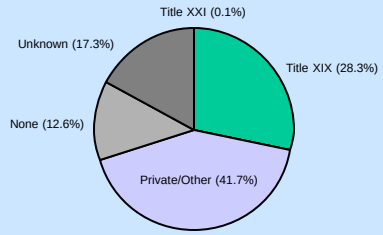
(services received by fewer than 20% of children and families)



Source: Kansas Early Intervention Longitudinal Study (1999–2002).

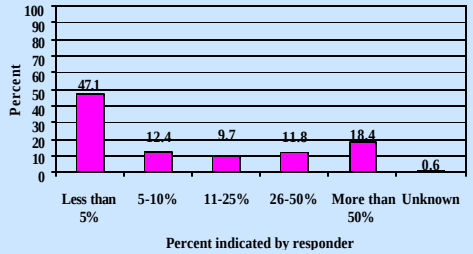
SHS Primary Sources of Coverage

Title V (Total Served 11,486)



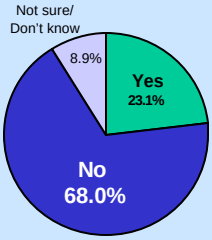
Source: SHS - BCYF, KDHE, 2003

SHS Percent of Eligible Children Receiving CSHCN Services



Source: SHS Provider Survey, 1997

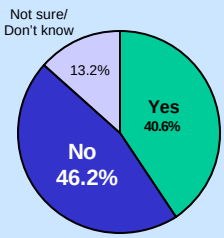
SHS Is Provider Aware of MADIN Telephone Number



MADIN – "Make A Difference Information Network", toll -free telephone number, (800) 332-6262

Source: SHS Provider Survey, 1997

SHS Is Provider Aware that SHS Can Authorize Diagnostic Evaluation at No Cost to Family



Source: SHS Provider Survey, 1997

Target Population

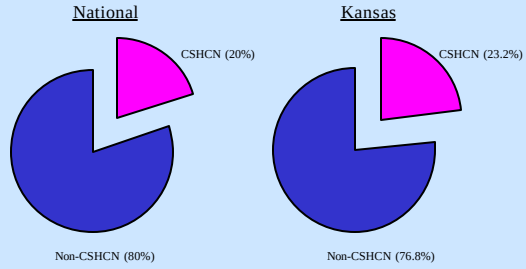
All children with special health care needs in Kansas.

Children with special health care needs are those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Goal

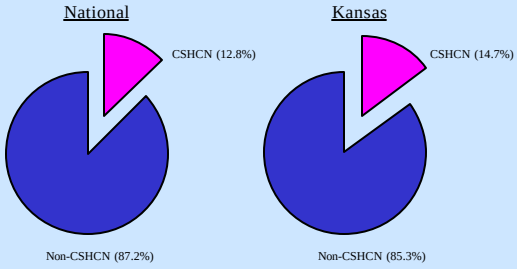
To enhance the health of Kansas children with special health care needs in partnership with families and communities.

Prevalence of Children with Special Health Care Needs: Households



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

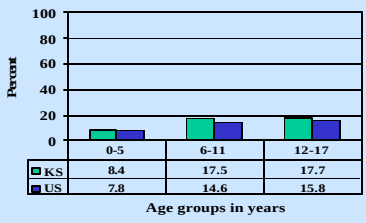
Prevalence of Children with Special Health Care Needs: Persons



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

CSHCN Prevalence in KS by Selected Demographic Characteristics

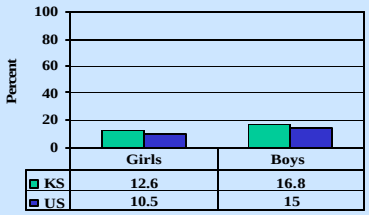
Age



Source: National CSHCN Survey, 2001 (Age 0-17 yrs.)

CSHCN Prevalence in KS by Selected Demographic Characteristics

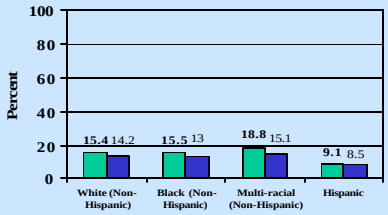
Gender



Source: National CSHCN Survey, 2001 (Age 0-17 yrs.)

CSHCN Prevalence in KS by Selected Demographic Characteristics

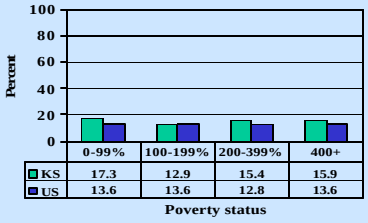
Race



Source: National CSHCN Survey, 2001 (Age 0-17 yrs.)

CSHCN Prevalence in KS by Selected Demographic Characteristics

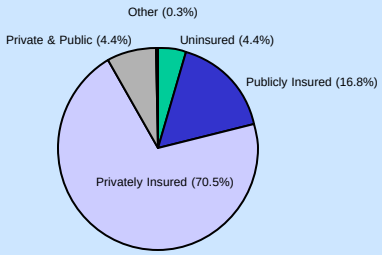
Household Poverty Status



	0-99%	100-199%	200-399%	400+
KS	17.3	12.9	15.4	15.9
US	13.6	13.6	12.8	13.6

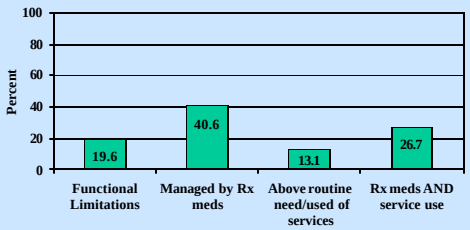
Source: National CSHCN Survey, 2001 (Age 0-17 yrs.)

Distribution of Kansas CSHCN by Insurance Status, 2001



Source: National CSHCN Survey, 2001 (Age 0-17 yrs.)

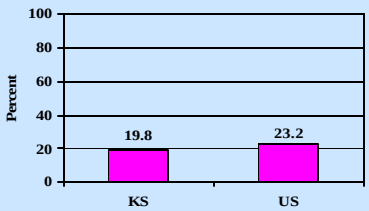
KS CSHCN by Complexity



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Child Health Indicator

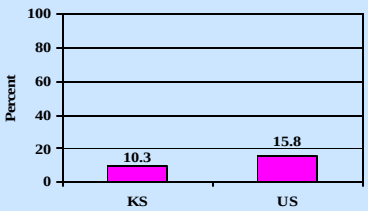
CSHCN 3. Percent of CSHCN whose health condition consistently and often greatly affect their daily activities.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Child Health Indicator

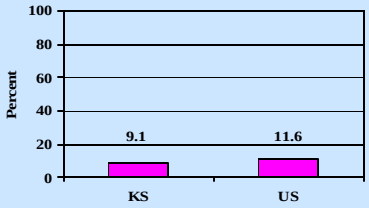
CSHCN 4. Percent of CSHCN with 11 or more days of school absences due to illness.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Coverage Indicator

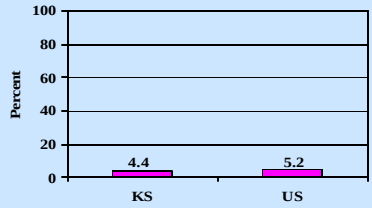
CSHCN 5. Percent of CSHCN without insurance at some point during the past year.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Coverage Indicator

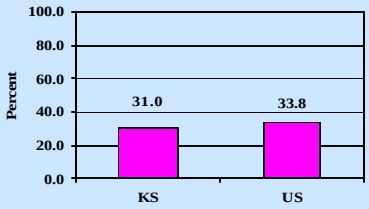
CSHCN 6. Percent of CSHCN currently uninsured.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Coverage Indicator

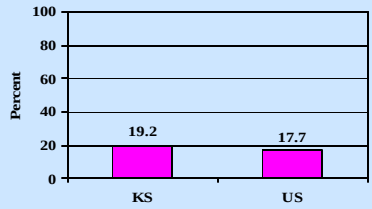
CSHCN 7. Percent of currently insured CSHCN with coverage that is not adequate.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Access to Care Indicator

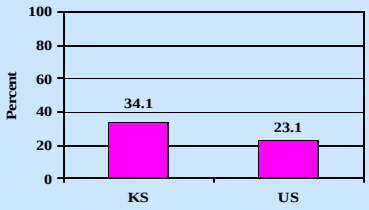
CSHCN 8. Percent of CSHCN with one or more unmet needs for Specific health care services.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Access to Care Indicator

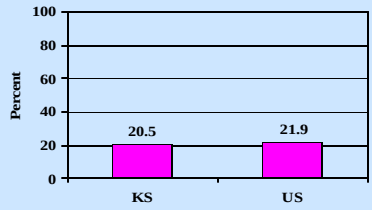
CSHCN 9. Percent of CSHCN whose families needed but did not get all respite are, genetic counseling and/or mental health services.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Access to Care Indicator

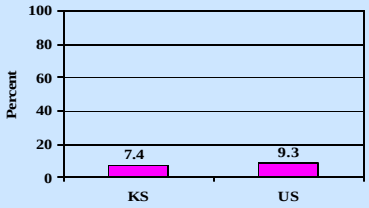
CSHCN 10. Percent of CSHCN needing specialty care who had referral.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Access to Care Indicator

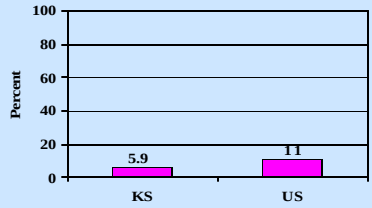
CSHCN 11. Percent of CSHCN without a usual source of care (or who rely on the emergency room).



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Access to Care Indicator

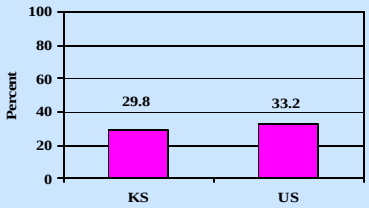
CSHCN 12. Percent of CSHCN without a personal doctor or nurse.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Family-Centered Care Indicator

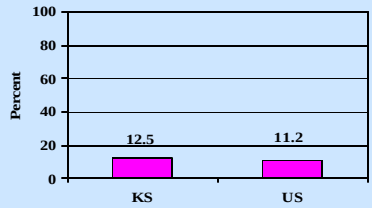
CSHCN 13. Percent of CSHCN without family-centered care.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Impact on Family Indicator

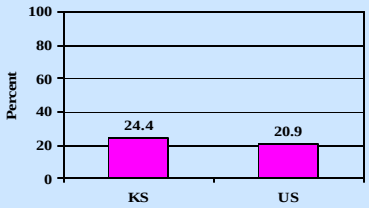
CSHCN 14. Percent of CSHCN whose families pay $1,000 or more in medical expenses per year.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Impact on Family Indicator

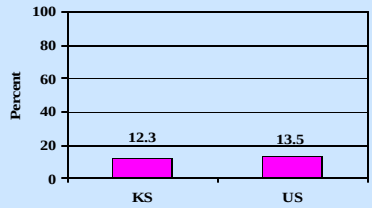
CSHCN 15. Percent of CSHCN whose families experienced Financial problems due to child's health needs.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Impact on Family Indicator

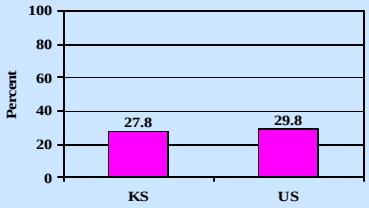
CSHCN 16. Percent of CSHCN whose families spend 11 or more Hours per week providing and/or coordinating health care for child.



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

Impact on Family Indicator

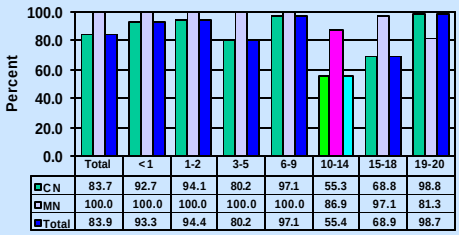
CSHCN 17. Percent of CSHCN whose health needs caused Family members to cut back or stop working



Source: National CSHCN Survey, 2001 (Age 0 -17 yrs.)

SCHIP VS. MEDICAID

KAN BE HEALTHY SCREENING RATIO

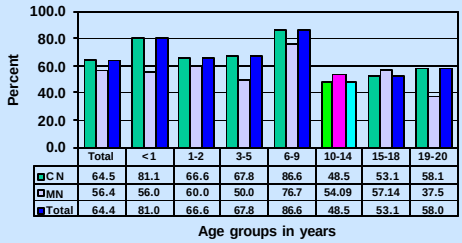


	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	83.7	92.7	94.1	80.2	97.1	55.3	68.8	98.8
MN	100.0	100.0	100.0	100.0	100.0	86.9	97.1	81.3
Total	83.9	93.3	94.4	80.2	97.1	55.4	68.9	98.7

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

KAN BE HEALTHY PARTICIPANT RATIO

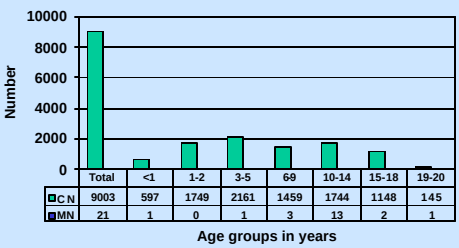


	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	64.5	81.1	66.6	67.8	86.6	48.5	53.1	58.1
MN	56.4	56.0	60.0	50.0	76.7	54.09	57.14	37.5
Total	64.4	81.0	66.6	67.8	86.6	48.5	53.1	58.0

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

KAN BE HEALTHY
Number of eligible referred for corrective treatment

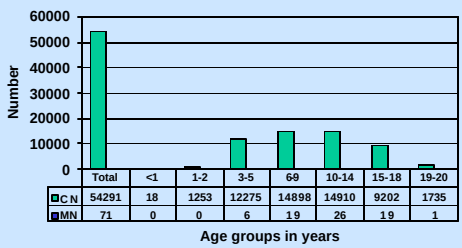


	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	9003	597	1749	2161	1459	1744	1148	145
MN	21	1	0	1	3	13	2	1

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

KAN BE HEALTHY
Number of eligible receiving any dental services

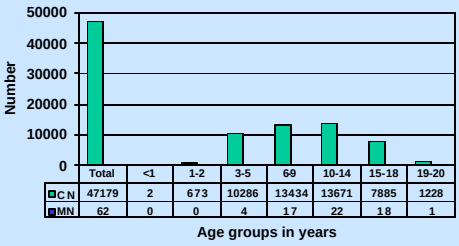


	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	54291	18	1253	12275	14898	14910	9202	1735
MN	71	0	0	6	19	26	19	1

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

KAN BE HEALTHY
Number of eligible receiving preventable dental services

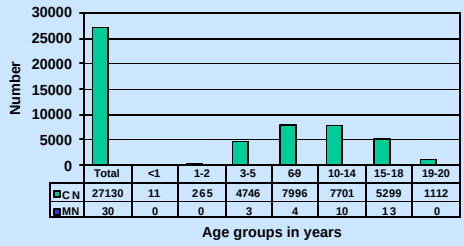


	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	47179	2	673	10286	13434	13671	7885	1228
MN	62	0	0	4	17	22	18	1

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

KAN BE HEALTHY
Number of eligible receiving dental treatment services

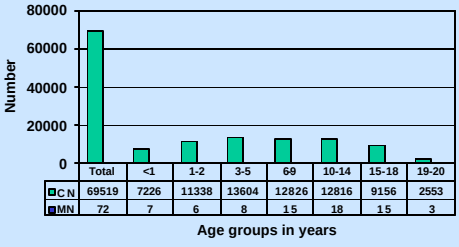


	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	27130	11	265	4746	7996	7701	5299	1112
MN	30	0	0	3	4	10	13	0

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

KAN BE HEALTHY
Total number of eligible enrolled in managed care arrangements

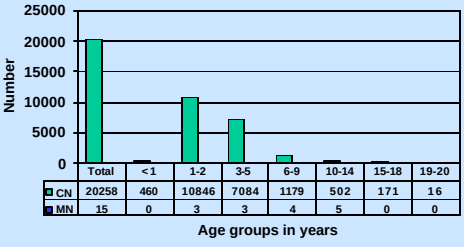


	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	69519	7226	11338	13604	12826	12816	9156	2553
MN	72	7	6	8	15	18	15	3

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

KAN BE HEALTHY
Total number of screening blood lead tests



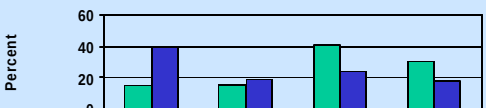
	Total	<1	1-2	3-5	6-9	10-14	15-18	19-20
CN	20258	460	10846	7084	1179	502	171	16
MN	15	0	3	3	4	5	0	0

Age groups in years

Note: CN – Categorically Needy; MN – Medically Needy
Source: KBH annual participant report. Report Period: 10/1/2002-9/30/2003

SCHIP Tends to Enroll Older Children Than Medicaid
(Age <19 yrs.)

SCHIP vs. Medicaid



	<3	3-5	6-11	12-18
SCHIP	14.5	15.5	40.9	30.2
Medicaid	39.8	18.4	23.9	17.9

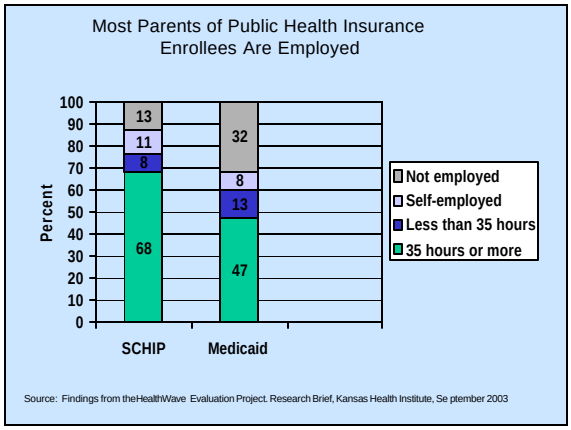
Age groups in years

Note: SCHIP (State Children's Health Insurance Program) - HealthWave in Kansas
Source: Findings from the HealthWave Evaluation Project. Research Brief, Kansas Health Institute, September 2003

SCHIP Families Have Higher Education, Greater Income, and Are More Likely to Have Two Parents

	SCHIP	Medicaid
Educational Attainment of Head of Household		
Less than High School	6%	9%
High School Graduate	58%	65%
Some College	22%	20%
College Graduate or Higher	14%	6%
Family Income <150% of Federal Poverty Level*	68%	81%
Number of Parents in Household		
Two	55%	45%
One	45%	54%

*In 2001, 150% of the Federal Poverty Level was $26,475 for a family of four.
Totals may not sum to 100% because of rounding.
Source: Findings from the HealthWave Evaluation Project. Research Brief, Kansas Health Institute, September 2003


Most Parents of Public Health Insurance Enrollees Are Employed
Percent
100
90
80
70
60
50
40
30
20
10
0
13
11
8
68
32
8
13
47
SCHIP
Medicaid
Not employed
Self-employed
Less than 35 hours
35 hours or more
Source: Findings from theHealthWave Evaluation Project. Research Brief, Kansas Health Institute, Se ptember 2003

Appendix D.3. CSHCN Data

State Profiles (Total child population, 0-17 years old)			Region VII States			Selected States				
	KS	US	Iowa	Missouri	Nebraska	Colorado	Oregon	Rhode Island	South Carolina	Utah
	%	%	%	%	%	%	%	%	%	%
Demographic Indicator										
% of children with special health care needs age 0 to 17: Households	23.2	20.0	19.6	22.5	20.5	19.1	21.2	22.9	21.0	19.9
% of children with special health care needs age 0 to 17: Person	14.7	12.8	12.3	15.0	12.8	11.5	13.2	14.1	13.2	11.0
Age 0-5	8.4	7.8	6.3	8.0	6.4	6.4	7.1	8.3	8.4	5.2
Age 6-11	17.5	14.6	14.2	17.5	13.7	13.0	14.3	15.7	15.6	11.9
Age 12-17	17.7	15.8	15.9	19.1	17.5	14.7	17.8	18.0	15.1	16.2
Female	12.6	10.5	10.4	12.5	11.2	9.1	12.3	11.8	11.5	9.9
Male	16.8	15.0	14.2	17.5	14.3	13.7	14.0	16.4	14.9	12.0
White (Non-Hispanic)	15.4	14.2	12.4	15.5	13.2	12.8	14.1	14.8	14.4	11.5
Black or African American (Non-Hispanic)	15.5	13.0	11.1	13.3	21.1	11.4	9.8	14.0	11.7	12.4
Multi-racial (Non-Hispanic)	18.8	15.1	22.0	16.8	9.0	18.4	13.0	20.6	14.1	14.4
Asian (Non-Hispanic)	N/A	4.4	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Native American/Alaskan Native (Non-Hispanic)	N/A	16.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Native Hawaiian/Pacific Islander (Non-Hispanic)	N/A	9.6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Hispanic	9.1	8.5	7.3	12.6	6.0	7.5	8.3	9.8	10.9	7.5
Household poverty status										
0-99% FPL	17.3	13.6	16.7	18.0	14.9	9.0	12.2	15.8	14.6	12.4
100-199% FPL	12.9	13.6	14.1	17.5	12.5	12.2	13.7	17.1	15.2	11.7
200-399% FPL	15.4	12.8	11.2	14.8	12.5	12.3	13.8	13.8	12.0	10.5
400% FPL or greater	15.9	13.6	12.5	13.8	13.0	12.0	14.0	13.3	14.7	11.5
Child Health Indicator										
1. % of CSHCN whose health conditions consistently and often greatly affect their daily activities.	19.8	23.2	16.4	23.9	24.1	19.1	24.6	18.4	20.5	26.5
2. % of CSHCN with 11 or more days of school absences due to illness.	10.3	15.8	11.8	13.6	17.9	10.2	22.7	13.7	17.2	19.3
Coverage Indicator										
3. % of CSHCN without insurance at some point during the past year.	9.1	11.6	10.4	7.2	8.4	9.3	15.4	6.9	11.5	11.8
4. % of CSHCN currently uninsured.	4.4	5.2	4.3	3.1	3.6	4.3	6.3	2.3	4.5	5.2
5. % of currently insured CSHCN with coverage that is not adequate.	31.0	33.8	28.4	30.0	30.3	35.9	35.8	26.6	35.4	36.3

Appendix D.3. CSHCN Data

State Profiles (Total child population, 0-17 years old)			Region VII States			Selected States				
	KS	US	Iowa	Missouri	Nebraska	Colorado	Oregon	Rhode Island	South Carolina	Utah
	%	%	%	%	%	%	%	%	%	%
Access to Care Indicator										
6. % of CSHCN with one or more unmet needs for specific health care services.	19.2	17.7	10.6	15.6	11.1	18.3	23.1	13.2	15.2	19.1
7. % of CSHCN whose families needed but did not get all respite care, genetic counseling and/or mental health services.	34.1	23.1	17.2	27.7	21.3	28.2	34.8	20.3	17.9	29.3
8. % of CSHCN needing specialty care who had problems getting a referral.	20.5	21.9	14.0	16.4	18.1	28.4	24.1	16.8	24.1	23.2
9. % of CSHCN without a usual source of care (or who rely on the emergency room).	7.4	9.3	12.1	8.4	11.7	9.0	12.7	10.3	9.6	10.1
10. % of CSHCN without a personal doctor or nurse.	5.9	11.0	8.3	7.2	9.2	11.7	7.5	6.0	11.3	7.0
Family-Centered Care Indicator										
11. % of CSHCN without family-centered care.	29.8	33.2	29.9	31.5	31.1	29.9	32.0	31.6	28.9	28.7
Impact on Family Indicator										
12. % of CSHCN whose families pay $1,000 or more in medical expenses per year.	12.5	11.2	9.6	10.4	12.4	17.6	12.0	5.2	14.6	15.5
13. % of CSHCN whose families experienced financial problems due to child's health needs.	24.4	20.9	19.4	19.6	20.0	20.4	24.2	14.8	25.3	22.3
14. % of CSHCN whose families spend 11 or more hours per week providing and/or coordinating health care for child.	12.3	13.5	10.9	12.7	14.6	9.6	13.1	11.0	17.7	10.3
15. % of CSHCN whose health needs caused family members to cut back or stop working	27.8	29.8	23.6	28.0	24.8	30.4	32.7	26.7	32.6	25.2
Note: * estimates do not meet the National Center for Health Statistics standard for reliability or precision. The relative standard error is greater than or equal to 30%.										
Data Source: Centers for Disease Control and Prevention, National Center for Health Statistics, State and Local Area Integrated Telephone Survey, National Survey of Children with Special Health Care Needs, 2001										
Version: Revised sampling weights, version 2										
Analysis Date: April 28, 2003										

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Appendix E.1

Instructions for SWOT Analysis

1. Review your workgroup's priority and strategy results.

2. For each strategy, discuss the strengths, weaknesses, opportunities, and threats that are relevant to undertaking the specified activity. Examples of factors to consider are provided for each component of the analysis.

   Note: Do not be concerned if the list of strategies your workgroup developed for each priority area is not yet fleshed out. Think about the range of activities that could be undertaken to address the priority health issue, and consider what factors will help or hinder progress toward the population health goal.

3. As you discuss each priority health issue and its accompanying strategies, record the strengths, weaknesses, opportunities, and threats on the worksheet and/or on newsprint. After all three workgroups have completed their analysis, the SWOT Analyses will be reported back to the expert panel, and the consultant will assist in identifying cross-cutting strategic issues.

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Appendix E.2

Kansas MCH2010 Capacity Assessment
October 29, 2004

Capacity Needs Worksheet Instructions

This worksheet is designed to be used with the CAST-5 Capacity Needs Tool as follows:

1. *Read through each item in the Capacity Needs Tool, including the bulleted list of examples.*
2. *For each, determine the status of that capacity in the state MCH system and mark "have" or "need" on the worksheet below.*
3. *Refer to the bulleted examples and write in specifics about the capacity needed.*
4. *For each "need," indicate an importance level for developing or enhancing that capacity (low, medium, or high).*
5. *Identify stakeholders (people, organizations, agencies, etc.) who will be instrumental partners in building that capacity.*
6. *Identify the first step(s) for KDHE in beginning to develop or enhance that capacity for the MCH system.*

Note: Examples are given at the back of this handout.

Capacity Need Add in specifics from the examples given or from your discussion.	Have	Need	Importance low, medium, high	Instrumental Stakeholders	First Steps
Structural Resources					
1) Authority and funding sufficient for functioning at the desired level of performance	☐	☐			
2) Routine, two-way communication channels or mechanisms with relevant constituencies	☐	☐			
3) Access to up-to-date science, policy, and programmatic information	☐	☐			
4) Partnership mechanisms (e.g., collaborative planning processes and community advisory structures)	☐	☐			
5) Workforce capacity institutionalized through job descriptions, contract language about skills and credentials, training programs, and routine assessments of capacity and training plans	☐	☐			

Capacity Need Add in specifics from the examples given or from your discussion.	Have	Need	Importance low, medium, high	Instrumental Stakeholders	First Steps
6) Mechanisms for accountability and quality improvement	☐	☐			
7) Formal protocols and guidance for all aspects of assessment, planning, and evaluation cycle	☐	☐			
Data / Information Systems					
8) Access to timely program and population data from relevant public and private sources	☐	☐			
9) Supportive environment for data sharing	☐	☐			
10) Adequate data infrastructure	☐	☐			
Organizational Relationships					
11) State *health* department/agencies/programs	☐	☐			

Capacity Need Add in specifics from the examples given or from your discussion.	Have	Need	Importance low, medium, high	Instrumental Stakeholders	First Steps
12) Other relevant state agencies	☐	☐			
13) Insurers and insurance oversight stakeholders	☐	☐			
14) Local providers of health and other services	☐	☐			
15) Superstructure of local health operations and state-local linkages	☐	☐			
16) State and national entities enhancing analytical and programmatic capacity	☐	☐			
17) National governmental sources of data	☐	☐			

Capacity Need Add in specifics from the examples given or from your discussion.	Have	Need	Importance low, medium, high	Instrumental Stakeholders	First Steps
18) State and local policymakers	☐	☐			
19) Non-governmental advocates, funders, and resources for state and local public health activities	☐	☐			
20) Businesses	☐	☐			
Competencies/Skills					
21) Communication and data translation skills	☐	☐			
22) Ability to work effectively with public and private organizations/agencies and constituencies	☐	☐			
23) Ability to influence the policymaking process	☐	☐			

Capacity Need Add in specifics from the examples given or from your discussion.	Have	Need	Importance low, medium, high	Instrumental Stakeholders	First Steps
24) Experience and expertise in working with and in communities	☐	☐			
25) Management and organizational development skills	☐	☐			
26) Knowledge and understanding of the state context	☐	☐			
27) Data and analytic skills	☐	☐			
28) Knowledge of MCH and related content areas	☐	☐			

Appendix F.1

The following email message was sent to MCH2010 Panel of Experts after Meeting #1.

Dear MCH2010 Panel Member:

Thank you for your participation in our first Maternal Child Health (MCH) Needs Assessment meeting on June 25th, 2004. Before we finalize plans for the second meeting, please take a moment to answer these questions. Your feedback will help us make this assessment process, with the ultimate goal of improving the health of Kansas women and children, as effective as possible.

1. What part of the process so far have you found to be **most** valuable? Why?

2. What part of the process so far have you found to be **least** valuable? Why?

3. What additional comments or suggestions do you have?

Thank you for your feedback. We look forward to seeing you August 16th for the next meeting.

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Appendix F.2

Panel of Experts Evaluation Form
Meeting #2

Please complete this evaluation form by the end of the day. Your feedback is important as we finish the needs assessment and move towards action. Please continue your comments on the back, as needed.

Workgroup: ❑ Pregnant Women & Infants ❑ Children & Adolescents ❑ CSHCN

1. Please rate:	**Excellent**	**Good**	**Fair**	**Poor**
a. Overall organization/structure	❑	❑	❑	❑
b. Meeting room(s)	❑	❑	❑	❑
c. Lunch & snacks	❑	❑	❑	❑
d. Quality of presentation/instructions	❑	❑	❑	❑
e. Facilitation of workgroups	❑	❑	❑	❑

Comments:

2. What part of the process so far have you found to be the *most* valuable? Why?

3. What part of the process so far have you found to be the *least* valuable? Why?

4. Additional comments/suggestions you have:

Name *(Optional)* _____

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Appendix F.3

Panel of Experts Evaluation Form
Meeting #3

Please complete this evaluation form by the end of the day. Your feedback is important in finishing this process. Please continue your comments on the back, as needed.

Workgroup: ❑ Pregnant Women & Infants ❑ Children & Adolescents ❑ CSHCN

1. Please rate:	**Excellent**	**Good**	**Fair**	**Poor**
a. Overall organization/structure	❑	❑	❑	❑
b. Meeting room(s)	❑	❑	❑	❑
c. Lunch & snacks	❑	❑	❑	❑
d. Quality of presentation/instructions	❑	❑	❑	❑
e. Facilitation of workgroups	❑	❑	❑	❑

Comments:

2. What part of the process have you found to be the *most* valuable? Why?

3. What part of the process have you found to be the *least* valuable? Why?

4. Additional comments/suggestions you have:

Name *(Optional)* _____

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Appendix G.1

Pregnant Women and Infants Top Three Priority Results from August 16th Meeting

Top Three Priorities:

1) Increase early and comprehensive health care before, during, and after pregnancy.

2) Reduce premature births and low birthweight

3) Increase breastfeeding

Note: Priority and strategy wording has been refined as suggested by Bureau for Children, Youth, and Families staff.

Identified Priority #1: Increase early and comprehensive health care before, during, and after pregnancy.

Type of Action	Strategies
Provide services directly – Specific activities	1. Provide the "Centering Pregnancy Program" model. 2. Provide enabling services such as case management to assess individual needs and set up a goal plan. 3. Develop system to help undocumented women access perinatal care.
Contract with others to provide service – Specific activities	1. Ensure referral resources for dental treatment, mental health, substance abuse treatment, and educational services as needed. 2. Facilitate referrals to food assistance and nutrition programs such as WIC. 3. Provide interpreters for linguistically isolated as needed. 4. Develop coalitions in disparate populations to advise programs on access/links. 5. Provide genetic counseling.
Regulate the activity – Specific activities	1. Change statute to allow PRAMS[1].
Educate public, providers, etc. – Specific activities	1. Teach preconceptional and interconceptual health through school based programs and public/private health care providers. 2. Educate public/private providers in nutrition, abuse screening, cultural sensitivity care (models available at National Perinatal Association Web site).
Systems development – Specific activities	1. Streamline Medicaid application & verification. 2. Educate public related to access to services and health issues in populations with disparities. 3. Adopt and promote The American College of Obstetricians and Gynecologists (ACOG)'s standards of care before, during, and after pregnancy. 4. Increase HealthWave eligibility to 200% of poverty level. 5. Increase Medicaid and HealthWave eligibility to undocumented pregnant women.

Identified Priority #1: Increase early and comprehensive health care before, during, and after pregnancy.

Type of Action	Strategies
Data systems improvement – Specific activities	1. Monitor the physical, economic, and social health of Kansas mothers and newborns with PRAMS[1]. 2. Expand BRFSS (Behavioral Risk Factor Surveillance System) to sample at the county level. 3. Unify data collection in the Maternal Child Health programs with a model similar to PedNESS[2] and PNSS[2]. 4. Implement Birth Defects Registry through CDC resources.

Notes:

1. PRAMS: The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project that collects state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

2. PedNESS: The Pediatric Nutrition Surveillance System (PedNSS) is a program-based surveillance system developed to monitor the nutritional status of infants and children in high-risk population groups. It is established on data collected through the Special Supplemental Food Program for Women, Infants, and Children (WIC).

3. PNSS: The Pregnancy Nutrition Surveillance System (PNSS) is a program-based surveillance system developed to assist health professionals in identifying and reducing pregnancy-related health risks that contribute to adverse pregnancy outcomes. It is established on data collected through the Special Supplemental Food Program for Women, Infants, and Children (WIC).

Identified Priority #2: Reduce the premature births and low birthweight.

Type of Action	Strategies
Provide services directly – Specific activities	1. Provide easy to use preconception health tools for the health care community. 2. Ensure that all pregnant women have access to early and comprehensive care. 3. Provide prenatal smoking cessation programs. 4. Assure smoking cessation and substance abuse services are available before conception.

Identified Priority # 2: <u>Reduce the premature births and low birthweight.</u>

Type of Action	Strategies
Contract with others to provide service – Specific activities	1. Create partnerships to provide service and support for all women in their reproductive years. 2. Contract with dentists to provide prenatal screening and pay for the care that is needed. 3. Refer to WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) for nutritional screening (using USDA new nutritional interviewing strategy). 4. Incorporate prenatal smoking cessation in clinical visits. 5. Identify pregnancies where there was a previous preterm birth, provide a case manager. 6. Develop coalitions in disparate populations to advise programs on access/links.
Regulate the activity – Specific activities	
Educate public, providers, etc. – Specific activities	1. Encourage providers to review signs and symptoms of labor at or around 20th week of gestation. 2. Encourage public and providers to provide "Tender Loving Care" in 20-30 week window of pregnancy.
Systems development – Specific activities	1. Reinvigorate regionalization of Neonatal Intensive Care Units (NICUs) (maternal transfer of high risk pregnancies), particularly to smaller hospitals. 2. Insurance coverage for maternal transfer for high risk pregnancies and "back" transfers. 3. Encourage providers to use national standards (national guidelines for reproductive technology).
Data systems improvement – Specific activities	1. Monitor the physical, economic, and social health of Kansas mothers and newborns with PRAMS[1].

Notes:

1. PRAMS: The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project that collects state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Identified Priority #3: Increase breastfeeding.

Type of Action	Strategies
Provide Services Directly	1. Provide certified breast feeding education in every health department. 2. Assure support service for breast feeding moms and families. 3. Encourage and involve public and private employers in creating "breastfeeding friendly" workplaces.
Contract With Others to Provide Service	1. Encourage all hospitals to adopt "Baby-Friendly Hospital Initiative" created by World Health Organization. 2. Formalize a working relationship with the La Leche League for consultation to MCH programs. 3. Create toll free number for breast feeding consultation.
Regulate the Activity	1. Lobby to ensure a women's right to breastfeed at work (Security Benefit and the Insurance Commissioner's office have good programs to support breastfeeding in the workplace.) 2. Provide tax incentives to employers. 3. Promote nursing niches in public facilities.
Educate Public, Providers, etc.	1. Lobby to ensure a women's right to breastfeed at work especially when infant is 6 months to one year of age. 2. Develop standards of care to support breastfeeding. 3. Certify very Healthy Start home visitor to be a breast feeding educator. 4. Educate employers about benefits of breastfeeding. 5. Target identified minorities with education/support to foster breastfeeding.
Systems Development	1. Hire certified breast feeding educator at the state level to coordinate health department educators. 2. Website development for breastfeeding resources.
Data Systems Improvement	1. Monitor the physical, economic, and social health of Kansas mothers and newborns with PRAMS[1].

Notes:

1. PRAMS: The Pregnancy Risk Assessment Monitoring System (PRAMS) is a surveillance project that collects state-specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

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Appendix G.2

Children and Adolescents Top Priority Results from August 16th Meeting

Top Priorities:

1) Improve behavioral/mental health.
2) Reduce overweight.
3) Reduce injury and death.

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4) Reduce teen pregnancy and sexually transmitted diseases (STDs).
5) Improve oral health.
6) Improve asthma treatment.

Note: Priority and strategy wording has been refined as suggested by Bureau for Children, Youth, and Families staff.

Identified Priority #1: <u>Improve behavioral/mental health.</u>

Type of Action	Strategies
Provide services directly – Specific activities	1. Linkages with The Consortium, Inc.[1]: Better linkages and information to Local Health Departments on how to refer to services. 2. Early detection/screening: More focused screening for behavioral health, mental health, and high-risk indicators/behaviors. 3. Physician extender reimbursement for behavioral health/mental health screening: Provide reimbursement to physician extenders (e.g., nurse, medical assistant) for this type of focused screening. 4. Family preservation intervention.
Contract with others to provide service – Specific activities	1. Contract with agencies for identification of high-risk behaviors and proper screening. For example, contract with The Consortium, Inc.[1] to train physician extenders, Infant Toddler program staff, Parents As Teachers staff, and others, on how to properly screen for behavioral/mental health issues.
Regulate the activity – Specific activities	1. Consider a Kansas Department of Health and Environment (KDHE) screening policy for mental health issues in perinatal programs and child & adolescent (e.g., Kan Be Healthy) services. Perhaps use stronger language or other incentives to be sure this occurs.
Educate public, providers, etc. – Specific activities	1. Educate the public on normal child & adolescent developmental milestones so parents and others know what to expect. 2. Encourage provider refocus on family and social history (Bright Futures[2]). 3. Identify family literacy issues for both national and foreign-born clients. 4. Family preservation interventions.
Systems development – Specific activities	1. Better use and application of screening tools for risk behaviors (depression, drugs, violence, etc.). The American Academy of Pediatrics (AAP) has good screening tools available. 2. Use clinic information systems to help incorporate screening tools. 3. Better utilization of age-appropriate handouts for parents on developmental milestones and expectations. (AAP and Bright Futures[2] are resources.) 4. Address cultural competency issues related to behavioral/mental health. (Not just language or literacy, but also what cultural norms related to behaviors.)

Identified Priority #1: <u>Improve behavioral/mental health.</u>

Data systems improvement – Specific activities	1. Identify incidence of evidence-based behavioral health diagnosis. 2. Evaluate proper testing/screening prior to diagnosis. (How many children were properly evaluated before they were diagnosed?)

Notes:

1. The Consortium, Inc. is a private not-for-profit behavioral healthcare provider sponsored organization (PSO) that provides a variety of Administrative Services Organization (ASO) products and functions for public and commercial purchasers. The Consortium, Inc. was created by the 29 Community Mental Health Centers of Kansas. For more information, see www.ksmhc.org.

2. Bright Futures, initiated by the Maternal and Child Health Bureau (MCHB) over a decade ago, is a philosophy and approach that is dedicated to the principle that every child deserves to be healthy, and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community. The American Academy of Pediatrics is currently working with MCHB to revise Bright Futures guidelines and accompanying materials, to develop new materials, and to promote implementation efforts among health care professionals, public/private partners with key child health constituencies, and communities and families. For more information, see brightfutures.aap.org.

Identified Priority #2: <u>Reduce overweight.</u>

Type of Action	Strategies
Provide services directly – Specific activities	1. Provide health education. Partner with K-State Extension, Kansas Action for Healthy Kids. 2. Reimbursement for at-risk and overweight management and counseling.
Contract with others to provide service – Specific activities	1. Reimbursement of dieticians for BMI[1] (body mass index) screening, evaluation, and management. Reimburse schools for BMI collection. (Who is responsible?) 2. Work with state and local parks and recreation departments to come up with safe indoor and outdoor arenas for activities for children.

Identified Priority #2: <u>Reduce overweight.</u>

Type of Action	Strategies
Regulate the activity – Specific activities	1. Institute a policy for reimbursement for screening of obesity, which, in turn, will result in better data. 2. Mandate nutrition and physical education classes back in schools. 3. Increase intramural sports. (Evaluate trend towards pay to play; this may decrease the number of children actively involved in sports.) 4. Mandate better screening for nutrition in day cares. 5. Turn off vending machines until after lunch in schools. 6. Fund schools adequately so vending machines are not necessary to raise revenue.
Educate public, providers, etc. – Specific activities	1. Collaborate with Bright Futures[2], school nurses, physical education programs, school health education programs, K-State Extension, Kansas Action for Healthy Kids, WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), and others on education efforts. 2. Educate parents and providers on expected growth curves, proper development, and intervention strategies. 3. Educate public of consequences of overweight children. 4. Encourage women to breastfeed.
Systems development – Specific activities	1. Structure systems and medical claims processing so BMI can be recorded and processed in data systems. 2. Establish a formal multi-disciplinary program. Collaboration with private practice, public health insurance, schools, day cares, etc. statewide.
Data systems improvement – Specific activities	1. Institute a statewide policy to begin collecting BMI[1]. Identify potential sources of BMI data (schools, Medicaid, KAN Be Healthy, etc.) Collaborate to collect BMI[1] data. 2. Add modifier to KAN Be Healthy for BMI[1] so it can be collected.

Notes:

1. BMI: Body mass index is defined as weight in kilograms divided by height in meters squared. BMI is commonly used to classify overweight and obesity among adults and is recommended for identifying children who are overweight or at risk for becoming overweight.

Identified Priority #2: Reduce overweight.

Type of Action	Strategies

2. Bright Futures, initiated by the Maternal and Child Health Bureau (MCHB) over a decade ago, is a philosophy and approach that is dedicated to the principle that every child deserves to be healthy, and that optimal health involves a trusting relationship between the health professional, the child, the family, and the community. The American Academy of Pediatrics is currently working with MCHB to revise Bright Futures guidelines and accompanying materials, to develop new materials, and to promote implementation efforts among health care professionals, public/private partners with key child health constituencies, and communities and families. For more information, see brightfutures.aap.org.

Identified Priority #3: Reduce injury and death.

Type of Action	Strategies
Provide services directly – Specific activities	1. Discussed link between mental health and behaviors. Provide adolescent mental health services. Provide school-based mental health. 2. Provide interventions through healthy start/home visitor (e.g. make sure parents have smoke detectors).
Contract with others to provide service – Specific activities	1. Provide incentives to parents to make sure they have proper intervention (e.g., booster seats, fence around swimming pool, smoke detectors, etc.). 2. Collaborate with pediatricians, poison control centers, burn centers, and others. 3. Provide flexible funds to local communities.
Regulate the activity – Specific activities	1. Child passenger safety legislation (booster seats for children age 4 to 8 years, primary enforcement for kids under18 years). 2. Local bike helmet ordinances. 3. Child access to firearms (injury and suicide prevention; youth suicide success rate). 4. Graduated drivers' licenses. 5. Alcohol-related legislation. 6. Child endangerment legislation.

Identified Priority #3: Reduce injury and death.

Type of Action	Strategies
Educate public, providers, etc. – Specific activities	1. Public engagement campaign (not just awareness). Possible issues: playground safety, booster seat safety targeting kids, access to firearms, overweight, kids in cars, safe routes to school. Target groups: teens, teens - alcohol, child care centers. 2. Problem with using aquatic facilities as day care.
Systems development – Specific activities	1. Incentives to local health departments to incorporate injury prevention into WIC (Special Supplemental Nutrition Program for Women, Infants, and Children), Healthy Start Home Visitor, and school-based health programs. (Examples: Discuss booster seats at the time of immunizations; discuss smoke detectors and other home safety issues through Health Start Home Visitor program.) 2. Provide flexible funding for communities. 3. Help with coalition building at community level. 4. Work with car safety for special needs children (physicians, reimbursements).
Data systems improvement – Specific activities	1. Better collection of cost data - what does it cost hospitals and insurance companies for injury and death? If we could show the real cost of injuries, this could provide incentive for better injury prevention. 2. Increase accurate E-coding on hospital data. 3. Ongoing surveillance; continue strong support for child death review board. 4. Encouragement/incentives for hospitals to report cost data to the KS Trauma Registry (currently mandated but not enforced).

Note: Causes of injuries and deaths for targeted strategies includes motor vehicle accidents, suicides, falls, and burns.

Identified Priority #4: Reduce teen pregnancy and sexually transmitted diseases (STDs).

Type of Action	Strategies
Provide services directly – Specific activities	1. Kansas Department of Health and Environment (KDHE) provide education to direct service providers. Train-the-trainer approach.
Contract with others to provide service – Specific activities	1. Contract with agencies like the YWCA to provide comprehensive sexual education in all middle schools & high schools. Providing access to contraception on a wider scale (e.g., longer hours, more in schools). 2. Provide access to contraceptives on a wider scale (e.g., longer hours, greater access in schools).
Regulate the activity – Specific activities	1. Require all students to take a health class. 2. Report adults having sex with underage teens.
Educate public, providers, etc. – Specific activities	1. Media campaign to change what is acceptable for teen sexual behavior and change attitudes about teen sexual behavior and sexual coercion. 2. Educate service providers on cultural norms of the Hispanic population. 3. Educate parents on how to talk to kids about sexual issues and what services are available for them. 4. Educate to discourage repeat teen pregnancies.
Systems development – Specific activities	1. Connection and coordination of teen services (drug & alcohol, mental health, contraception, STDs, etc.)
Data systems improvement – Specific activities	1. Report repeat teen pregnancy rates. "Repeat teen pregnancies" are adolescents with two or more pregnancies.

Identified Priority #5: <u>Improve oral health.</u>

Type of Action	Strategies
Provide services directly – Specific activities	1. Screenings & referrals. 2. Pilot school-based program: Registered dental hygienists perform screenings, fluoride varnishes, and cleanings in schools. 3. United Methodist Health Ministry Fund ToolKit grant starts September 1. Puts registered dental hygienists in alternative practice sites and venues such as Local Health Departments, Head Start, schools, home health, and Community Health Clinics. Continue working with hygienists and those agencies as this is implemented. 4. DIAGNodent (laser fluorescent device): Work with school and public health nurses to screen and refer to dentists.
Contract with others to provide service – Specific activities	1. Contract with dentists and hygienists to provide direct services after they do basic screening survey. 2. Secure pool of money to follow-up on needs after Kansas Mission of Mercy.
Regulate the activity – Specific activities	1. No soda and vending machines in schools (unless water and fruit). 2. Provide direct Medicaid reimbursement for dental hygienists (as in 17 other states) so they can receive payment for services providing in schools. (SRS change required.) 3. Community water fluoride.
Educate public, providers, etc. – Specific activities	1. KS Action for Children media campaign on how oral health is part of total health. 2. Educate OB/Gyn physicians on how important oral health is to perinatal health. 3. Educate pediatrician offices, ARNPs, public health nurses, and school nurses about oral health, normal and abnormal structures of the mouth. 4. Educate parents on wiping baby's mouth after feeding, don't put to bed with bottle, etc.
Systems development – Specific activities	1. Pediatricians, ARNPs, and RNs apply fluoride varnish in private practice & receive reimbursement. 2. Anticipatory Guidance (wipe baby's mouth after feeding; don't put to bed with bottle; I sit up - I use a cup; no sugary liquids; reverse pressure seal; no grazing/constant carbohydrates).

Identified Priority #5: Improve oral health.

Type of Action	Strategies
Data systems improvement – Specific activities	1. Perform open mouth survey every other year or every three years. 2. Determine prevalence of sealants, caries. Collect data on access to services (how often dentist is seen). 3. Trend analysis on sealants, caries, access to services. 4. Why no Medicaid providers?

Identified Priority #6: Improve asthma treatment.

Type of Action	Strategies
Provide services directly – Specific activities	1. Probably not a lot that Kansas Department of Health and Environment (KDHE) can do regarding direct patient services, but KDHE could be huge player in asthma media campaign involving IAQ (indoor air quality).
Contract with others to provide service – Specific activities	1. Contract with Local Health Departments and others (American Lung Association/Kansas and Kansas Asthma Coalition) to improve diagnosis and evidence-based treatment of asthma. 2. Specifically, work with American Lung Association of Kansas and the Kansas Asthma Coalition to provide the following Asthma Management programs: a. Open Airways for Schools (asthma education and management program) b. Tools for Schools (indoor air quality program for schools and other public buildings) c. Counting on You (indoor air quality program for day care centers and in-home day care providers) d. Living with Asthma (public asthma educations programs for adults, teens and children) e. Asthma Educator Workshops (professional education with approved CE credit for healthcare professionals)

Identified Priority #6: <u>Improve asthma treatment.</u>

Type of Action	Strategies
Regulate the activity – Specific activities	1. Regulate third party reimbursement - reimburse asthma educators certified through approved providers. For example, reimburse physician assistances, pharmacists, etc. who have passed national exam. (American Lung Association/Kansas staff can provide this ongoing education.) 2. This legislative session, a bill was passed to allow 6th-12th to self-administer inhaler. This should be all children with approval of physician and school nurse. Important to make sure child has been educated to administer properly.
Educate public, providers, etc. – Specific activities	1. Educate providers on evidence-based National Heart, Lung, and Blood Institute (NHLBI) guidelines already in place for asthma.
Systems development – Specific activities	1. Centers for Disease Control and Prevention's (CDC's) priorities in their "Steps to a Healthier US" initiative are obesity, asthma, mental health. Recommend that MCH Children & Adolescent priorities match these. Also, KDHE has applied for CDC capacity-building grant. If awarded, this would provide an asthma coordinator for the state.
Data systems improvement – Specific activities	1. Continue to collect BRFSS (Behavioral Risk Factor Surveillance System) data related to asthma.

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Appendix G.3

Children with Special Health Care Needs (CSHCN) Top Three Priority Results from August 16th Meeting

Top Three Priorities and Suggested Strategies:

1) Improved Access to Mental Health, **Medical and Transitional Services**.

→Advocate at Kansas legislature for improved insurance coverage for CSHCN.
*Insurance/financial issues.
→Expand provider network.
→Improved access to healthcare through telemedicine.
→Outreach clinics.
→Training in medical home.
→Educate federally qualified health centers on caring for CSHCN.
→Pre-certification of providers for caring for CSHCN while they're in school.
→Develop and coordinate case manager to connect to support services.
→Implement transportation/reimbursement mileage to specialists/PCP.
→Interpreter services to cultural competency training to address language barriers.

2) Improve capacity for data of Kansas-CSHCN. **(This priority has been incorporated into action/strategy.)**

→Identify demographics of CSHCN.
→Insurance coverage.
→Data about children with specific medical conditions.
→Identify alternative resources.
→Determine measurable outcomes.
→Address barriers to information sharing.
→Develop a new data tool for developing and reporting of data.

3) Develop interventions to improve child's health condition and **financial impact on family**.

→Provide specialty clinic services.
→Access available insurance.
→Case management to help coordinate care and services.
→Family not working.
→Access additional resources.
→Web site development.

Note: The language of the selected priorities and action/strategy steps on the following pages have been refined by the KDHE CSHCN staff.

Identified Priority #1: <u>Increase care within a medical home.</u>

Type of Action	Strategies
Provide services directly – Specific activities	1. Provide outreach clinics in underserved areas of Kansas. 2. Interpreter services and cultural competency training to address language barriers.
Contract with others to provide service – Specific activities	1. Contract with primary care providers. 2. Case management to help coordinate care and wrap around services.
Regulate the activity – Specific activities	
Educate public, providers, etc. – Specific activities	1. Training in medical home. a. Professional (MD, nurse, social worker) level of education. b. Parent to parent. c. Part C and B, school nurses, health departments. 2. Develop a mentoring program available to primary care providers via American Academy of Pediatrics. 3. Add parent or adult role model to physician office and clinics and as a client-to-client resource. 4. Promote the ability of local programs to serve high-risk populations, including CSHCN by providing education, technical assistance and resources.
Systems development – specific activities	1. Increase knowledge of providers for caring for CSHCN while they're in school. 2. Update current provider list. 3. Identify areas lacking specialty providers 4. Add out of state providers to providers list. 5. Support American Academy of Pediatrics medical home initiative.

Identified Priority #1: Increase care within a medical home.

Type of Action	Strategies
Data systems improvement – Specific activities	1. Develop capacity for data linkages between CSHCN and other data bases such as Department of Education, Injury Prevention, WIC, and Insurance. 2. Identify demographics of CSHCN by county or SRS regions. 3. Develop data capacity for children with specific medical conditions. 4. Develop easy access resource database for providers. 5. Data collection to determine outcomes identified. 6. Address barriers to information sharing. 7. Insure data capacity for collecting and reporting primary language and foreign-born.

Identified Priority #2: Improve transitional service systems for CSHCN.

Type of Action	Strategies
Provide services directly – Specific activities	1. Refer to appropriate resources (e.g., Part C, vocational rehabilitation program, etc.). 2. Refer to Social Security Supplemental Income, Medicaid, and Insurance providers. 3. Involve adolescents in SHS application process. Review health care plan with them.
Contract with others to provide service – Specific activities	1. Promote services as a part of medical home services. 2. Support workshops like "Youth Leadership Forum" or "Families Together Weekends" focused on transition. 3. Any contracts will specify agreed upon outcomes.
Regulate the activity – Specific activities	

Identified Priority #2: <u>Improve transitional service systems for CSHCN.</u>

Type of Action	Strategies
Educate public, providers, etc. – Specific activities	1. Develop partnership with resource center for independent living to enhance public and child knowledge. 2. Continue to work with Department of Education in planning annual KANTRANS conference to incorporate medical transition. 3. Educate families, CSHCN, and providers about learn the essentials of self-care and self-determination to enhance their health status. 4. Provide training for hospital discharge planners and office nurses to promote self-care and determination options to families. 5. Use school nurse and public/private nurse's newsletters to educate on self-care and self-determination models
Systems development – specific activities	1. Suggest magazines such as "Exceptional Parent" add a feature addressing transition. 2. Assure that transition councils incorporate medical components in transition planning.
Data systems improvement – Specific activities	1. Establish data linkage capacity with Kansas Department of Education. 2. Develop and implement exit survey for all children exiting the CSHCN program to assess transitional supports. 3. Data collection to assure adequate participation via resource center. 4. Monitor number of IEPs (Individual Education Plans) that have action plans for transition.

Identified Priority #3: Decrease financial impact on CSHCN and their families.

Type of Action	Strategies
Provide services directly – Specific activities	1. Utilize telemedicine at local providers office instead of family having to travel for consult. 2. Better utilization of email and phone consults in lieu of office visit. 3. Promote "Youth of Kansas Equipment Exchange Program". 4. Design and fund a pilot project for management of cystic fibrosis, spina bifida, or seizure disorders. 5. Maintain direct services.
Contract with others to provide service – Specific activities	1. Increase case management capabilities by contracting with agencies working with CSHCN families. 2. Contract with providers to increase outreach clinics in rural Kansas. 3. Continue to support "Parent Advisory Group" to assure input and dissemination of Best Practices.
Regulate the activity – Specific activities	
Educate public, providers, etc. – Specific activities	1. Provide education about the importance of inclusion in day care centers. 2. Educate parents about availability of local resources through Part C, Early Head Start, Head Start, Friendly Visitors Program. 3. Educate families regarding services availability 4. Educate families about getting maximum benefits from insurance. 5. Provide training for day care providers and urge SRS to provide financial incentive to providers to accept stable CSHCN.
Systems development – specific activities	1. Collaborate with Child Care Licensing and Kansas Child Care Resource and Referral Association to maintain an updated list of day care providers trained to care for CSHCN. 2. Develop a program model between provider and parent for urgent messaging contact. 3. Support a reimbursement policy change in Medicaid reimbursement to allow payment of both specialist and primary provider (MD, school, therapist) for services provided same visit. 4. Support coverage of email and phone consults by insurance, Medicaid, etc. 5. Work with insurance commission to ensure Durable Medical Equipment coverage etc.

Identified Priority #3: Decrease financial impact on CSHCN and their families.

Type of Action	Strategies
Data systems improvement – Specific activities	1. Conduct a study to determine increase in CSHCN access to health services due to SRS data linkage. 2. Develop and implement a web-based data system linking the state office with outreach clinics. 3. Evaluate SHS policy for yearly evaluations with a specialist for eligibility criteria. 4. Collaborate with Child Care Licensing to track child care slots for CSHCN.

Appendix H

Capacity-Building Strategies Identified at August 2004 Meeting

At the second MCH 2010 meeting, in August 2004, the workgroups identified priority health needs and began drafting strategies to address those needs. At the October 29 meeting, workgroups will assess the MCH system's capacity to carry out those strategies and identify the resources that need to be developed or enhanced. Some of the strategies drafted at the August meeting are in and of themselves capacity-building strategies; they are listed below. Each workgroup should incorporate their capacity-building strategies into the list of capacity needs they draft during the October meeting. You may find other strategies on your list from the August meeting that you would classify as "capacity-building;" the lines can be fuzzy, since because activities and resources are so intertwined.

Pregnant Women and Infants Group	Children and Adolescents	CSHCN
Structural Resources: • Change statute to allow PRAMS • Adopt and promote ACOG's standards of care • Develop standards of care to support breastfeeding • Hire state-level breastfeeding education coordinator *Data/Information Systems:* • Expand BRFSS to sample at the county level • Unify data collection in MCH programs • Implement Birth Defects Registry through CDC resources • Website development *Organizational Relationships:* • Create partnerships and develop coalitions • Formalize relationship with La Leche League	*Structural Resources:* • Strengthen policy on KDHF mental health screening in perinatal and pediatric services *Data/Information Systems:* • Restructure IS so BMI can be recorded • Institute statewide policy on collection of BMI, ID data sources, etc. *Organizational Relationships:* • Enhance linkages with The Consortium and with LHDs • Partnerships with K-State extension, KS Action for Healthy Kids, parks and recreation departments, WIC, Bright Futures, school nurses, etc. etc. *Competencies/Skills:* • Training for "physician extenders," etc. on mental health screening	*Structural Resources:* • Update provider lists • Establish resource databases for providers • Incorporate outcomes into contracts *Data/Information Systems:* • Establish capacity to link data systems • Develop web-based data system linking state office with outreach clinics *Organizational Relationships:* • Collaboration and partnerships with other agencies • Cultural competency training and provision of interpreter services • Medical home training • Establish mentoring program

Appendix I.1

SWOT Analysis

Workgroup: ***Pregnant Women and Infants***

Priorities: *#1 Increase Early & Comprehensive Health Care Before, During, and After Pregnancy, #2 Reduce Premature Births and Low Birth Rate, and #3 Increase Breastfeeding*

Note: These are **summarized highlights** of the strengths, weaknesses, opportunities, and threats identified at Meeting #3.

Strengths:

- Good programs already in place (M & I [Maternal & Infant program], WIC [Women, Infants, and Children program], Healthy Start, Family Planning)
- Many programs are in same place (BCYF [Bureau for Children, Youth and Families])
- Some technology, systems already in place (e.g, WIC data system)
- Good efforts by others and excellent partners/potential partners in state (e.g., Success by Six, KAMU [Kansas Association for the Medically Underserved], Kansas Nutrition Network)
- Examples of effective programs in other states
- Effective models and initiatives from other sources (e.g., employer - Security Benefit breastfeeding policies, CDC models)
- Effective community-level programs and initiatives (e.g., community breastfeeding coalitions)
- Existing standards of care
- Number of local health departments in Kansas; local health department staff
- Society expresses support for children and their health
- Increase in society's use of Information Technology (IT) and IT infrastructure and access in Kansas
- Financial resources (e.g., Kansas Children's Cabinet and Trust fund – tobacco money)

Opportunities:

- Educate via technology
- Start educating consumers at a young age
- After-school programs
- Mass media, social marketing
- Educate employers (e.g., benefits to them for breastfeeding-friendly policies)
- Work with legislators, educate legislators
- Policy changes and tax incentives for encouraging breastfeeding
- Work with agencies to make processes more user-friendly (e.g., HealthWave clearinghouse)
- Increase reimbursements
- Develop coalitions to coordinate services
- Further developing new and existing data systems: PRAMS (Pregnancy Risk Assessment Monitoring System), BRFSS (Behavioral Risk Factor Surveillance System), PedNess (Pediatric Nutrition Surveillance System) and PNSS (Pregnancy Nutrition Surveillance System) (WIC data systems), PPOR (Perinatal Periods of Risk)
- Educate public and parents (e.g., on emotional and financial costs of prematurity, smoking cessation during clinic visits)
- Provide educational opportunities for providers (e.g., best practices, show benefit of data)
- Providers – use technology to reach, serve, screen, and treat clients
- Involve, coordinate with other organizations (Kansas Hospital Association, Kansas Perinatal Association, La Leche)
- Increase case management
- HIPAA (Health Insurance Portability and Accountability Act of 1996) open to interpretation
- Data from new birth certificate
- Technology systems available if funded

Weaknesses:

- Everyone is not reached through current programs
- People don't seek access to programs (pride, don't think they need programs)
- Public's limited access to technology
- Lack of culturally sensitive educational materials
- Language barriers, lack of interpreters
- Bureaucracy, overwhelming forms to fill out
- Time constraints of providers
- Poor reimbursement rates
- Lack of adequate financial resources, funding
- Lack of financial incentives (e.g., no incentives for dentists to provide prenatal screening and care)
- Rural access, transportation issues
- Dental and mental health not available for underserved
- Limited genetic counselling resources
- Not enough county-specific data
- Limited data monitoring systems, no organized system for data analysis
- No PRAMS (Pregnancy Risk Assessment Monitoring System)
- Lack of community-based programs (e.g., smoking cessation)
- Getting information to private providers; no quick, easy way to educate public and/or providers need to better education patients
- Mass media sends unrealistic message
- HIPAA issues related to case management, confidentiality concerns
- Limited hours for access
- Lack of necessary level of professional expertise (e.g., breastfeeding services)
- Public understanding (e.g., breasfeeding)

Threats:

- Budget cuts, lack of financial resources
- Insufficient insurance coverage
- Lack of personnel
- Time constraints
- Lack of creative thinking
- Legislators are uneducated on issues
- Public/consumers feel threatened (e.g., that children will be taken away)
- Public's view of entitlements
- Funding care for undocumented women
- Schools overloaded
- SRS offices have closed in some counties
- Resistance to regionalization of some care
- Current statutes
- HIPAA, need to protect confidentiality
- Clients can be overwhelmed with information
- Time constraints for teaching patient (e.g., new mothers in hospital)
- Lower population levels may decrease provider availability, especially in rural areas
- Ignorance and territorial issues
- Personal bias, attitudes

Appendix I.2

SWOT Analysis

Workgroup: ***Children and Adolescents***

Note: These are **summarized highlights** of the strengths, weaknesses, opportunities, and threats identified at Meeting #3.

Strengths:

- Results-oriented state and local coalitions, programs (e.g., injury prevention, asthma, teen pregnancy prevention)
- Advocacy groups
- Good partnerships on state and local level
- Community volunteers
- People committed to programs, issues
- Good infrastructure for some programs (e.g., injury prevention)
- Good integration of early childhood programs
- Third party payer for mental health
- Compelling data for some issues (e.g., injury prevention, teen pregnancy prevention)
- Multidisciplinary programs (e.g., obesity)
- Parish nursing programs
- New state dental director
- Emphasis on performance measurements and standards at national and state level
- Outside research expertise in state (e.g., Kansas Health Institute)
- Several foundations in state to provide funding for child health issues

Opportunities:

- Utilize data already there (e.g., school health data, private physicians)
- Identify more people for services through screening (e.g., mental health)
- Better utilize Initiatives, coalitions, more networking at state and local levels (Governor's Health Initiative, school health councils, asthma coalitions)
- Work together to meet, build new partnerships on common issues (e.g., conservative/liberal)
- Work with parish nursing programs
- Reinforce linkages (e.g., physical health and schools, physicians)
- Form Kansas Child Health Council similar to Kansas Perinatal Council
- Utilize role models (e.g., coaches, student athletes) and peer methods of education (e.g., teen pregnancy prevention)
- Target disparate populations
- Team/multidisciplinary provider approach (e.g., expand multidisciplinary ob
  esity program, family practice/pediatrics, teen pregnancy prevention and other risk behaviors)
- Utilize media: press releases, public service announcements for children, oral health "commercials"
- Take advantage of technology (e.g., computer games with physical exercise)
- Incorporate family into interventions (obesity, physical activity, sexuality, asthma), use family as resource
- New/pending legislation: dental hygienists receive reimbursement for services, asthma medication in schools

Weaknesses:

- Mental health assessment tools, shortage of mental health providers, waiting periods for mental health professionals
- Lack of public awareness and public will for certain issues (e.g., mental health, obesity)
- Need infrastructure for childhood (age 5-10) interventions
- Disparate needs (e.g., teen pregnancy declining overall, but Hispanic and African American still high)
- Have some best practices/programs that work, lack a way to replicate across the state and/or lack local capacity to implement (e.g., childhood obesity, injury prevention)
- Breastfeeding facilities
- Lack of industry involvement
- Lack of cost data (e.g., child passenger safety, obesity)
- Weak legislation for some issues (e.g., safety belt)
- Lacking state programs and/or coordinated coalitions for some issues (e.g., no state asthma program, no statewide intentional injury coalition)
- Kansas not taking advantage of all funding sources (e.g., not meeting all legislative requirements)
- Staff time, time in schools
- Fragmented family structures, overwhelmed families
- Privacy laws an obstruction
- Polarized society

Threats:

- Legislation
- Public opinion
- Social mandates
- Mental health issue slow to move
- Physical activity, mental health, wellness, falling by the wayside in schools due to time constraints
- Society sends mixed messages (e.g., breastfeeding and sending formula home from hospital)
- Values disagreements
- Vocal minority interest groups
- Strong lobbies from commercial companies
- Economic programs
- Overwhelmed families

Appendix I.3

SWOT Analysis

Workgroup: ***Children with Special Health Care Needs***

Note: These are **summarized highlights** of the strengths, weaknesses, opportunities, and threats identified at Meeting #3.

Strengths:

- Human
  - o Team players
  - o Collective work experience/expertise
  - o Heart for families and children/access
  - o Professional combinations
- Fiscal
  - o Telemedicine
  - o Base funding
  - o Epi available
  - o Outside resources
- Social/political
  - o Governor action
  - o Interagency collaboration
- Federal/State Involvement
  - o Movement toward local involvement
  - o More grants – local participation

Opportunities:

- Human
  - o Personal in-service training to increase knowledge
  - o Person to person contact with families and agencies
  - o Offering community care decreases burdens on families and numbers of children in current clinics
- Fiscal/Technological
  - o Grant writing
  - o Utilize university and graduate students
  - o Expand pilot projects
- State/Local Relationship
  - o Seamless care and services
  - o Individualized services based on local needs is opportunity to eliminate duplication – more collaboration and diversity
- Statutory/Regulation Changes
  - o Mandate an increase in providers
- Community/Business/Social/Political
  - o Interdisciplinary training
  - o Interagency access to data
  - o Create more integrated systems
  - o Marketing or renaming "Medical Home" concept

Weaknesses:

- Human
  - o Lack of state, maintain & use technology
  - o Overwork
  - o Judgmental attitudes
  - o Stagnating – losing sight of goals
  - o Personnel conflicts
  - o Personal stresses
- Fiscal/Budgetary
  - o Never enough money
  - o Not good data system
  - o Financial security (cuts)
  - o Lack of appropriate reimbursement for providers
  - o Opportunity to generate fiscal support
- Organizational Culture/Structure
  - o Time to go through appropriate channels
  - o Infrastructure to implement is not comprehensive and inclusive
  - o Lack of awareness and priority for appropriate training for health professionals
- Technological
  - o Inability to share data
- Local/State Involvement
  - o Duplication of services
  - o "Medical Home" terminology lacks uniform perception (buy-in) and understanding
  - o Efficiency sometimes = job loss, results in political backlash and loss of expertise
  - o Lack of collaborators and expertise

Threats:

- Statutory/Regulatory
  - o Money cuts
  - o Inadequate interpreter services
  - o Medicaid changes
  - o Regulations (HIPAA) restrict data sharing
- Organization/Re-organization
  - o Money cuts (key positions)
  - o Change with SRS secretary
- Social/Political
  - o Fear of unknown
  - o Unemployment = increased demands on programs
  - o Money cuts
  - o Transportation costs
  - o Decrease insurance coverage
  - o Political shifts = jobs/position changes and delivery
- Demographic
  - o Lack of specialists in rural areas
  - o Immigrant population
  - o Desire for isolation
- Cross-cutting
  - o Lack of buy-in from long-term funding sustainability

Appendix J.1

Capacity Needs Worksheet: Pregnant Women and Infants Workgroup

Note: Blue text denotes summarizes of Capacity Needs Worksheet comments submitted by the Pregnant Women and Infants group at meeting #3.

Capacity Need	Have	Need	Instrumental Stakeholders
Structural Resources			
1) Authority and funding sufficient for functioning at the desired level of performance • Statutory change to allow data monitoring system (e.g. PRAMS [Pregnancy Risk Assessment Monitoring System]) • Secure private funding sources • Secure funding to provide prenatal care to undocumented clients		X	Biostatisticians, Legislators
2) Routine, two-way communication channels or mechanisms with relevant constituencies • Improve communication with business, marketing, private providers		X	Providers, Business/Chamber, KS Nutrition Network, Media
3) Access to up-to-date science, policy, and programmatic information • Continue to improve link to academics	X	X	University/Colleges/Tech, Perinatal Association of Kansas
4) Partnership mechanisms (e.g., collaborative planning processes and community advisory structures) • Continue to build/ strengthen coalitions	X	X	La Leche, March of Dimes , KALHD (Kansas Association of Local Health Departments), Kansas Commission on Disability Concerns
5) Workforce capacity institutionalized through job descriptions, contract language about skills and credentials, training programs, and routine assessments of capacity and training plans • Promote board certified registered lactation consultant at state level		X	KALHD , Consumers, Hospitals
6) Mechanisms for accountability and quality improvement • Improve data monitoring systems • Improve analysis, interpretation and dissemination • Formalize accountability and quality improvement		X	Health Care Data Governing Board
7) Formal protocols and guidance for all aspects of assessment, planning, and evaluation cycle • Formalize plans to disseminate: Blue Book (guidelines for perinatal care put out by American Academy of Pediatrics and American College of Obstetricians), Baby Friendly Hospital Initiative, Rep. Tech.		X	
Data/Information Systems			
8) Access to timely program and population data from relevant public and private sources		X	
9) Supportive environment for data sharing		X	
10) Adequate data infrastructure		X	
Organizational Relationships			
11) State *health* department/agencies/programs • Need access-FIMR (Fetal and Infant Mortality Review)		X	Kansas Perinatal Council
12) Other relevant state agencies • Incorporate breastfeeding initiative into Hunger Plan & Physical Activity/Obesity Plan • Continue to work with SRS to insure access for all (i.e. some counties don't have office for transportation issues)		X	

Capacity Need	Have	Need	Instrumental Stakeholders
13) Insurers and insurance oversight stakeholders • Increase HealthWave participants by raising coverage and outreach and eligibility		X	
14) Local providers of health and other services • Train the Trainer Model (breast feeding comprehensive care) • Use new technology more	X	X	
15) Superstructure of local health operations and state-local linkages • Strengthen accountability to document measure/outcome from local to state		X	
16) State and national entities enhancing analytical and programmatic capacity • Support accreditation for local health dept. (MCH programs)		X	
17) National governmental sources of data • Need help with interpretation and application of data • Need to understand work force capacity R/T MCH providers (state level)	X	X	
18) State and local policymakers • State is excellent • Local is inconsistent	X		KALHD
19) Non-governmental advocates, funders, and resources for state and local public health activities • Cultivate more funding and other resources	X	X	
20) Businesses • Work with K.H.O. • Work with insurers and providers to cover prenatal, health promotion, breastfeeding, prematurity		X	
Competencies/Skills			
21) Communication and data translation skills • Increase capacity and skills with non-English speaking and health literacy	X	X	
22) Ability to work effectively with public and private organizations/agencies and constituencies	X		
23) Ability to influence the policymaking process • Present at coalition level • Work with Business Health Policy Committee (MCH must be at the table)	X	X	
24) Experience and expertise in working with and in communities • Utilize experience with bioterrorism in public health to build MCH programs		X	
25) Management and organizational development skills		X	
26) Knowledge and understanding of the state context			
27) Data and analytic skills • Analyze, interpret, and disseminate data at local and all levels		X	
28) Knowledge of MCH and related content areas			

Appendix J.2

Capacity Needs Worksheet: Children and Adolescents

Note: Blue text denotes summarizes of Capacity Needs Worksheet comments submitted by the Children and Adolescents group at meeting #3.

Capacity Need	Have	Need	Importance (low, med, high)	First Steps
1) Authority and funding sufficient for functioning at the desired level of performance • Insufficient resources, shrinking federal money due to shrinking proportion of population • Federal programs want to fund community-based rather than state • Better collect, utilize data to justify funding requests		✓	High	• Identify resources we do have • Look for funding sources other than federal grants
2) Routine, two-way communication channels or mechanisms with relevant constituencies • Good: newsletters, listserves • Need: communication between consumers and high-level policy makers	✓	✓	High	• Maintain lists to improve communication between consumers and high-level policy makers, know who constituents are and who is doing what • Use TRAIN Kansas
3) Access to up-to-date science, policy, and programmatic information • Certain issues have, others don't • Need implementation, utilization; lack of resources		✓	High	• Contact outside organizations (e.g., American Lung Association, American Diabetes Association) and ask them to help inform agency on up-to-date science and policy
4) Partnership mechanisms (e.g., collaborative planning processes and community advisory structures) • Not a single structure, but this isn't necessarily a weakness	✓			
5) Workforce capacity institutionalized through job descriptions, contract language about skills and credentials, training programs, and routine assessments of capacity and training plans • Do we have too much bureaucracy? • Low capacity at local levels		✓	Medium+	• Particular to each agency or group • Position/salary survey provided to local level; help local agencies share data about how they organize and staff positions
6) Mechanisms for accountability and quality improvement • Improving, is a need, but is already being addressed	✓			
7) Formal protocols and guidance for all aspects of assessment, planning, and evaluation cycle • There for the most part	✓			
8) Access to timely program and population data from relevant public and private sources • We need **timely** data and cost data		✓	High	• Pursue more ways to obtain private insurance data • Pursue ways to use preliminary data within a program to make decisions; need data faster • Ask universities, other agencies for ideas and assistance
9) Supportive environment for data sharing • Varies. Several examples of specific problems were given.		✓	High	• Better inform data users and data resources on HIPAA • Consider changing internal KDHE policies for improved data sharing • Build infrastructure so data can be accessed online
10) Adequate data infrastructure • Some antiquated systems		✓	High	• See above • Get ideas from other agencies and associations
11) Organizational relationship with state *health* department/agencies/programs • Do pretty well on this	✓			

Capacity Need	Have	Need	Importance (low, med, high)	First Steps
12) Organizational relationships with other relevant state agencies • May be MOU on file, but sometimes hard to find the right contact person • Early childhood is working well • Some one-on-one relationships are working well, but entire agency may not be working well together		✓	Low	
13) Organizational relationships with insurers and insurance oversight stakeholders • FirstGuard (Medicaid Managed Care) – good working relationship • Commercial, commercial managed care is a need		✓	Medium (data piece)	• Keep pursuing insurance data • Work with Office of Health Care Information to use data • Work with Kansas American Academy of Pediatrics Council (advocates for data sharing, dissemination)
14) Organizational relationships with local providers of health and other services • Needs to improve • Private agencies need to take initiative		✓	Medium	• Empower local agencies to seek assistance/network with state.
15) Superstructure of local health operations and state-local linkages • KALHD	✓			
16) State and national entities enhancing analytical and programmatic capacity • Resource opportunities that are not tapped		✓	Medium+	
17) National governmental sources of data • We do pretty well here	✓			
18) State and local policymakers • Some do well; others can do better	✓	✓	Medium	
19) Non-governmental advocates, funders, and resources for state and local public health activities • Need to do better	✓	✓	Low	
20) Businesses • Not doing much here; potential funding resource		✓	Medium	
21) Communication and data translation skills • Need more on the local level • As rapidly as technology changes, this is a continuous need	✓	✓	High	• Remain diligent. • Spend more time educating local agencies how to access data.
22) Ability to work effectively with public and private organizations/agencies and constituencies	✓			
23) Ability to influence the policymaking process • Need awareness of process of communicating to legislature • Make sure information from these three meetings is acted on	✓	✓	High	• Make local communities aware of issues and process • Widely disseminate results of this process
24) Experience and expertise in working with and in communities	✓+			
25) Management and organizational development skills • Cross-training, educating state and local staff, funding issues		✓	High	• Assign staff members to develop certain areas of expertise. • Improve continuing education and awareness of *all* staff (not just high level).
26) Knowledge and understanding of the state context	✓	✓	High	• Maintain diligence
27) Data and analytic skills • Have, but is a high need	✓	✓	High	• Common MCH database: look at what is collected now, common elements, future options
28) Knowledge of MCH and related content areas • Have some at state level, need in other areas	✓	✓	High	• Comprehensive MCH database: think of local and constituent needs as it is developed

Appendix J.3

Capacity Needs Worksheet: Children with Special Health Care Needs

Note: Blue text denotes summarizes of Capacity Needs Worksheet comments submitted by the CSHCN group at meeting #3.

Capacity Need	Have	Need	Importance (low, med, high)	Instrumental Stakeholders	First Steps
Structural Resources					
1) Authority and funding sufficient for functioning at the desired level of performance • Funding for communications coordinator	✓	✓	High	Federal, SRS (Social and Rehabilitation Services), KDHE, Providers	• Search for available grants • Prioritize grant opportunities • Submit grants
2) Routine, two-way communication channels or mechanisms with relevant constituencies • Position hired	✓	✓	High	Federal, KDHE, SRS, Providers, Clients, Public	• Quarterly meetings with stakeholders • Identify contact in each agency who reports to a central primary agency within KDHE to coordinate (e.g., a new position of community coordinator)
3) Access to up-to-date science, policy, and programmatic information • Process of pulling team members together to begin clearinghouse services		✓	High	All of the above	• Coordinator of communications
4) Partnership mechanisms (e.g., collaborative planning processes and community advisory structures) • Implement services		✓	High	All of the above	• Identify key players & what
5) Workforce capacity institutionalized through job descriptions, contract language about skills and credentials, training programs, and routine assessments of capacity and training plans • Establish quality assurance and follow through	✓	✓	High	Federal, KDHE, SRS, Providers	• All data from same source • Identify and develop key terms to be used across the board (e.g., Medical Home) • Coordinator of Communication could be the clearinghouse for what services are available where
6) Mechanisms for accountability and quality improvement					
7) Formal protocols and guidance for all aspects of assessment, planning, and evaluation cycle					
Data/Information Systems					
8) Access to timely program and population data from relevant public and private sources • Establish quality assurance and follow through		✓	High	KDHE and/or contractor, Information Systems, Department of Education, SRS, Infant Toddler	• Evaluate Computer Data Systems evaluation • Develop new web-based data system • Look at putting resources on KDHE website
9) Supportive environment for data sharing		✓	High	Parents, Medical Providers, Education, Insurance companies, Mental Health, Legal	• Begin discussion with Kansas Department of Education regarding what data is available • Look at available data
10) Adequate data infrastructure		✓	High	Human staff support, KDHE Information Systems, Software upgrades	• Evaluate web-based data system • Put information on web page

Capacity Need	Have	Need	Importance (low, med, high)	Instrumental Stakeholders	First Steps
Organizational Relationships					
11) State *health* department/agencies/programs • Needs to be stronger	✓	✓		Office of Local and Rural Health, BCYF (Bureau for Children, Youth, and Families)	
12) Other relevant state agencies • For example, Kansas Department of Transportation and Area Agency on Aging • Let others look at issues to offer support					
13) Insurers and insurance oversight stakeholders • Develop stronger relationships and training capacity for consistency • Lack of capacity for flexibility of resource use • Lack of equal access to resources • May not have preferred provider in area		✓		Use CCM (Certified Case Management) standards to develop training protocol	• Modify contract language to allow neutral or cost saving use of funds • Use funds saved direct to indirect support
14) Local providers of health and other services • Need referral acceptance to appropriate level of care		✓		American Academy of Pediatrics, Family Practice providers, Hospitals, Office of Local and Rural Health	• Telemedicine hookup for expanded specialty access and consultation
15) Superstructure of local health operations and state-local linkages • Communication occurs but not sure if they know MCH goals • Expand the superstructure				Board of Healing Arts, Board of Nursing, KDHE, Kansas Health Institute, Kansas Hospital Association	• Fill positions and/or delegate authority to support locals
16) State and national entities enhancing analytical and programmatic capacity • Develop to reduce fragmentation		✓			• Use grad students for development program • Software data sharing • Utilize present national technical support and university information services
17) National governmental sources of data	✓				
18) State and local policymakers					• Community leaders at the table to increase awareness, become more educated on the issues and educational opportunities
19) Non-governmental advocates, funders, and resources for state and local public health activities • Strengthen	✓				• One-on-one contact • Share data • Discover common interests
20) Businesses • Insurance policies • Employment opportunities for family and CSHCN • Economic support to sustain service delivery					• Market economic impact on the community as related to academics, high school and college graduation, decreased juvenile delinquency

Capacity Need	Have	Need	Importance (low, med, high)	Instrumental Stakeholders	First Steps
Competencies/Skills					
21) Communication and data translation skills 27) Data and analytic skills					1. State web site that reports research/data information – also post grant opportunities 2. More epidemiologists – someone you can call and request data for grants, etc. Perhaps attach a fee to this service. 3. Use telehealth system to consult/educate local areas about data development and interpretation.
22) Ability to work effectively with public and private organizations/agencies and constituencies					
23) Ability to influence the policymaking process					
24) Experience and expertise in working with and in communities					
25) Management and organizational development skills					1. Identify strengths of university and corporations and incorporate more trainings, educational experiences into MCH program development 2. Plan several (2) day trainings that include education on issues related to management and organization development.
26) Knowledge and understanding of the state context					
28) Knowledge of MCH and related content areas					